A Study of Adolescent Children of Parents With Schizophrenia - their Stress, Coping Resources and Mental Health

By

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Abstract

The purpose of this research is to study the nature of stress in terms of stressors and perceived stress, coping resources (*social self-efficacy, self-esteem, mental health knowledge and attitude toward ex-mental patients*), mental health of the adolescent children of schizophrenic patients, and the relationships amongst these variables.

The present study was cross-sectional in nature and a structured questionnaire had been administered to 88 adolescent children of schizophrenic patients. The outcome of this study indicated that stressors of management problems were most frequently faced by the respondents, meanwhile, "patient's relapse of mental illness at home" and "financial problem in family" caused greatest perceived stress. Regarding *social self-efficacy*, over 40% of the respondents displayed difficulties with respect to certain social situations. As for *self-esteem*, only 60% of the respondents felt that they were satisfied with themselves. According to the findings, the respondents' *knowledge about schizophrenia* and mental health services in Hong Kong was far from adequate. Concerning their *attitude to the ex-mental patients,* it was found that a very large proportion of the respondents showed their unwillingness to closely get along with an ex-mental patient. Moreover, the data with regard to their mental health status showed that over half of them were a group of "at risk" clientele.

The results of this study indicated that most of the respondents ranked "*pschological assistance/counseling*" as the first priority service that their schizophrenic parents needed. Regarding their own most needed services, they ranked "*Education on management of psychiatric problems*" and *"Training on stress management"* as the first and secondary priorities. Among the respondents, over 10% of them considered the medical social service as ineffective though a large proportion of respondents were satisfied with it.

With respect to the relationships amongst perceived stress and coping resources, it was found that only *self-esteem* and correct *knowledge about schizophrenia* were significantly correlated with perceived stress. Concerning the relationships amongst coping resources and mental health, it was observed that *social self-efficacy* and *self-esteem* were significantly correlated with mental health; whereas *attitude toward ex-mental patients* was restricted to be significantly correlated with the measure of hopelessness only.

Echoing to the expressed needs of the respondents, it is suggested that some specialized services may be provided for this group of clientele. These services include (1) education about mental health, nature of mental illness and utilization of mental health services; (2) management techniques to handle the problems arising from mental patients; (3) stress management programs; (4) training on crisis intervention to empower them to deal with some crisis situations; (5) community supportive service, (e.g. respite service,

specialized home help / family aid service, after-care service and volunteer service for the schizophrenic patients so as to alleviate the burden of their family members including the adolescent children); (6) specialized counselling programs and training camps; (7) therapeutic groups, self-help groups, social skills training groups, and self-developmental groups may be organized for them with a view to i) enhancing their *self-esteem*, *social self-efficacy*, *knowledge* and their favourable and accepting *attitudes* to the mentally ill, ii) reducing their perceived stress, and iii) promoting their psychological well-being.

TABLE OF CONTENTS

LIST OF TABLES

Chapter One

Introduction

The present study aims to identify the stressors faced by the adolescent children of schizophrenic patients and to explore the stress they experienced, their personal coping resources and psychological well-being.

Family members of the schizophrenic patients play a more important care-giving role under the trend of deinstitutionalization and community care in the recent years (Jones, 1988). They may bear a heavy burden and face the ample strains when they are not equipped with sufficient knowledge and skills to handle the problems caused by the mental patients. Moreover, they will be more likely to experience anxieties and helplessness if the support from the community-based services is inadequate to relieve them from the pressure.

Noh and Turner (1987) remarked that the most common problem reported by the family members was the effect on their own mental health. Moreover, the presence and behavior of the ex-hospitalized patients became the major sources of strain and distress in family. Nevertheless, Creer and Wing (1974) reported that family members of schizophrenics rarely complained about the difficulties for reasons of shame, guilt, denial of problems or unfavorable experience in their help-seeking process. Although many studies have been done on the caregivers of the mentally ill (Gubman & Tessler, 1987;

Hatfield & Lefley, 1987; Torrey, 1988), children are usually excluded from the study of caregivers. However, there are increasing concerns about children of the mentally ill parents who have a substantially increased risk of developing psychiatric disorder during childhood (Rutter, 1966; Rutter & Quinton, 1984) or adulthood (Watt, Anthony, Wynne & Rolf, 1984).

In Hong Kong, it was estimated that there were over 12,000 patients suffering from functional psychosis and attending the out-patient clinics. Furthermore, there were about 230,000 people suffering from different kinds of mental illness (Hong Kong Government, 1990). Although the number of parents suffering from mental problems is unknown, their impact on the family should not be under-estimated. In the process of promoting mental health of children in Hong Kong, there is a need to study the impact of parental mental illness on children.

Schizophrenics constitute the major category of the mentally ill persons receiving different rehabilitation services in Hong Kong. Many schizophrenic patients are discharged home after hospitalized only for a short period of time, and it is a source of concern for mental health workers. In these cases, their families have to take up a long-term and crucial role in taking care of the patients (Chan, 1993). Concerning the research about the family members of mental patients in Hong Kong, among the few studies, Lieh Mak & Pan (1987) revealed that 65% of the relatives of the mentally ill reported to be heavily burdened. Wong's (1991) study of "Chronic Strain, Coping and Mental Health

of the Mentally-ill" also showed that a significant proportion of the caregivers suffered from poor mental health, and over 50% of caregivers experienced substantial stress in caring for the schizophrenics. Chan (1993) reported that most of the caregivers bear the burden in financial, social and emotional areas. Sun (1994) also stated that over 50% of the families in his study did not function well in family functioning.

Apart from the adult caregivers, the children of the mentally ill may also experience a stressful family environment, encounter some specific problems, bear heavy burdens or face a lot of management difficulties in their day-to-day interaction with their mentally ill parents. In studying the children of schizophrenic parents, some related questions are raised: Would parents with mental illness cause stressful family environment? What are the practical problems faced by their children? What are the sources of stress of those children? What is the prevalence of emotional or psychosocial difficulties among them? What coping resources do they possess and whether these resources are effective or not? What is their attitude and degree of acceptance to their mentally ill parents? Have they acquired sufficient knowledge to understand and manage the problems arising from their schizophrenic parents? What are the mental health conditions of those children? Do they have a sense of hopelessness? The list is endless, but among the questions which left unanswered, perhaps psychological well-being of those children is the most essential one. However, there is no systematic study to explore the impact of

parental mental illness on children in Hong Kong. It is therefore worthwhile to study this topic under the specific local socio-cultural context. Empirical findings in this area may provide more comprehensive information for the mental health professionals to render proper service for the children of the mentally ill parents. As a matter of fact, the children's stressors, problems and risk factors to mental health need early identification and intervention. Since the studies of help-seeking pattern of adolescents indicate that they seldom turn to professionals for assistance (Li & Ng, 1992), it requires more sensitivity and patience from social workers to explore their situation and then provide timely and efficacious service to them.

The local studies about the relatives of mental patients seem to focus on caregivers' burdens, stress, social support and some environmental factors. In fact, the personal resources including sense of mastery, hardiness, self-esteem, etc. are also the precious inner resources which may be utilized any time by the person and are worth studying by researchers. In clinical practice, the author found that some adolescents who lived under the same roof with their schizophrenic parents might display different mental health status. Further assessment also revealed that they had different personal attributes. Some queries were raised: "Are personal attributes a kind of important resources to reduce the impact of stressful events on the psychological well-being?" "Are these coping resources associated with perceived stress and do they have strong relationships with mental health ?"

Concerning the personal coping resources of family members of schizophrenic patients, the sense of mastery was briefly explored in Wong's (1991) study. "How about coping resources of other positive beliefs, e.g. *self-efficacy and self-esteem*?" "Do correct *knowledge* they have acquired in understanding mental illness help them face the specific management problems caused by the schizophrenic patients?" and "What is the *attitude* of family members toward the patients?" and "Would *self-efficacy, self-esteem, mental health knowledge and attitude toward ex-mental patients* be important factors influencing family members' perception of stress, as well as their own psychological well-being?" These questions would be answered in the present study.

As the mental health of adolescents have drawn much concern in Hong Kong and the high prevalence rate of depression is found among the youngsters (BGCAHK, 1992; Chan, 1991; Shek, 1988, 1990; Shek & Mak, 1992; Wong, 1990), one of the purposes of this study is to examine whether the teenage children of mentally-ill parents are more vulnerable to the psychological distress. Teenagers are selected as the target group in this study because adolescence is a very crucial stage to build up their personal identity, self-concept, sex role, and to learn the values necessary to function adequately and independently. "Nothing is more crucial than the development of an adequate self-concept in adolescents" (Rice, 1984). Moreover, adolescents'

attitude toward ex-mental patients may be reviewed on the basis of the previous studies (Shek, 1988).

The objectives of this study are as follows:

(1) to identify the prevalence of ***stressors*** that are commonly faced and to examine the intensity of ***perceived stress*** experienced by the adolescent children of schizophrenic patients;

(2) to examine the personal coping resources, i.e. ***social self-efficacy, self-esteem, knowledge about schizophrenia and attitude toward ex-mental patients*** of the adolescent children of schizophrenic patients.

(3) to understand the ***mental health*** condition of the adolescent children of schizophrenic patients.

(4) to look into the relationships among ***perceived stress, personal coping resources and mental health*** of the adolescent children of schizophrenic patients.

It is hoped that the findings gained from this study may provide some insights and information on the intervention strategies for service providers in helping the adolescent children of schizophrenic patients whose needs are always ignored.

This report is composed of eight chapters. Chapter 1 is an introduction. In Chapter 2, studies about the impact of parents' mental illness on their

children will be presented. In Chapter 3, literature review on the concepts of stress, coping and mental health will be discussed. In Chapter 4, the literature review concerning the relationships among the various variables under study, as well as the conceptual framework, research questions and hypotheses will be delineated. In Chapter 5, the research methodology will be introduced. The findings of this study will be presented in Chapter 6 and discussed in Chapter 7. Finally, the conclusions and recommendations will be made in Chapter 8, the last chapter.

Chapter Two

The Impact of Parental Mental Illness on Children

Many researchers argued that children did not develop mental health problems solely because of the amount of stress experience, but also depended on the influence of parental behavior on children (Bowlby, 1980; Weissman, 1983). The below studies showed that parental mental illness could risk the child's development and psychological well-being. In this chapter, the impact of general parental mental illness on children would be reviewed; and then the impact of parental affective disorder and schizophrenia on children would be discussed. It follows the comparison of parents with affective disorder and schizophrenia and then the discussion on the limitations of some empirical studies about children of the mentally-ill.

2.1 Impact of parental mental illness on children

The mental illness of a family member may be a traumatic experience to a person of any age. The impact on a child may not only be a sort of short-term traumatization, but also a domination of his/her early life experience. Clausen and Huffine (1979) stated that children of mental patients were subject to periodic disruption and to levels of conflict and uncertainty that would seriously impair the socialization process. Moreover, the mentally ill parents might have difficulties in

providing a role model for competent performance and emotional control for their children.

Rutter and Quinton (1984) conducted a 4-year prospective research to the families of 137 psychiatric patients (who had no specific diagnosis, but attending hospitals or clinics) with children aged under 15. In their study, a comparison was also made with a control group of families in the general population with children of 10 years old. They found that the children of psychiatric patients had an increased rate of persistent emotional and behavioural disturbance which tended to involve disorder of conduct. The findings also showed that the children of mentally ill patients had a substantially increased risk of developing psychiatric disorders during childhood. These findings implied that the patients' children might constitute a psychiatric 'at risk' group. In fact, many other studies had demonstrated the relations between psychiatric disorder in both parents and children (Rutter et al, 1984; Webster, 1992). However, no study concerning this aspect had ever been conducted in Hong Kong.

2.2 Studies about the impact of parental affective disorder on children

There had been increasing concern that the children of parents with affective disorders might be at risk for adjustment difficulties

(Beardslee, Bemporad, & Keller, 1984). Weissman and Paykel (1974) also found on the basis of parents' reports that depressed parents were more likely than non-depressed parents to have children with psychiatric symptoms which met the criteria for various DSM III disorders. Many researchers had established that children who had at least one parent with an affective disorder had a significantly increased rate of depression and other psychopathology when compared with children whose parents had no history of affective illness (Billings & Moos, 1983; Mcknew, Cytryn, Efron, Gershon & Buney, 1979). In other studies, children of depressed parents were also found to have adjustment problem (Morrison & Reid, 1993), significantly disturbed characteristics, and lower self-esteem (Hirsh, Moos & Reishl, 1985). For some other children, the parent's withdrawal due to depression was felt as a loss of guidance and boundaries and a loss of a model of behavior. Depending on the persuasiveness, severity, and recurring nature of psychiatric symptoms, the impact on the children's development could be short-term, subsiding with the parental recovery, or it could be long-term (Weissman, 1983).

The writings of Bowlby (1980) provided the conceptual framework for understanding both the short-term impact and long-term consequences of parent's depression on children. Many forms of psychiatric disorders were resulted from malfunctioning of a person's

capacity to make and maintain affectionate bonds. Therefore, the eruption of a clinical depression in a parent could be experienced by a child as a disruption of affectionate bonds. These children then developed symptoms in association with the parental depression and its social consequences.

Johnson (1986) stated that depressive symptoms could be regarded as an integral part of the schizophrenic process itself, being predominantly existent during the acute phase of the illness and not depending on other causal factors. In particular, it had been suggested that patients might manifest a depressive syndrome when their psychosis had aborted. Random interviews had suggested that neurotic symptoms, many of a depressive type (worrying, simple depression, loss of energy, loss of interest) were the principal symptoms causing distress to the chronic schizophrenic patient (Cheadle, Freeman, & Korer, 1978). Both depressive and schizophrenic parents might share the affective symptom dimension that was emotionally blunted or insensitive to the children's needs or signals. However, the schizophrenic parent might also be exposing the children to hallucinations, delusion and incongruent affect. Of course, it would be theoretically important to ask whether the parents with schizophrenia also had poor quality of parenting relationships with their young children and whether children of schizophrenic parents suffered from similar impacts as those of depressive parents.

2.3 Children of schizophrenic patients

Most assessments of families with a schizophrenic member had concentrated on the impact of family interaction on the patient (Leff & Vaughn, 1976). However, many researchers and mental health professionals had failed to recognize the burden of living with a schizophrenic person and the impact of distressed family interaction on the non-schizophrenic members (Hatfield, 1987). Among the family members, the parents or the spouses usually received more attention because of their roles as principal caregivers. Nevertheless, the children of the schizophrenic patients might also face the psychological stress of coping with patients' disturbed behavior, persistent disruption of household routine (e.g., night time wakening and irregular eating habits), and the problems of coping with the social withdrawal and awkward interpersonal behavior of the patient (Fallon, Boyd & McGill 1984; Hatfield, 1987). Therefore, they might experience considerable stress and great dissatisfaction in their relationship with their schizophrenic parents, and consequently, their mental health would be affected . In Hong Kong, some studies had been conducted to examine the mental health of adolescents of general population (Chan, 1991; Ngai, Law, Liu & Zhou, 1994; Shek, 1989; Wong, 1990) and had identified a considerable proportion of "high-risk" cases. Nevertheless, the studies about adolescent mental health of problematic families were

not available including the study concerning the stress, coping or mental health of children of the mentally ill.

Research on behaviors of psychotic mothers toward their children following an initial period of treatment for an acute schizophrenic episode suggested that many of these mothers were unable for some months to respond appropriately to the needs of the child (Garmezy, 1974; Rodnick & Goldstein, 1974). Rogler and Hollingshead (1965) also reported widespread neglect and child abuse in their study of families with a schizophrenic parent. Anthony (1976) reported that chronically psychotic patients had less severely disturbed children than did parents with acute disturbances, moreover, children were more disturbed by parental acting out behaviour than by parental avoidance and neglect. The above findings seemed to have some discrepancies with that of some other studies which reported that patients' residual symptoms such as social withdrawal and socially embarrassing behavior were the most annoying and most particularly hard to deal with (Creer & Wing, 1975). It is therefore interesting to explore which behaviors of the schizophrenics, in the local context, cause the most stressful experience in the family members.

2.3.1 *Effect of psychiatric symptoms and behavioral change*

Rutter (1966) found that the parent-child association of psychiatric disorder was the strongest when the parental symptoms directly affected or involved the children in some ways. It appeared that the children were most at risk when they were the target of parental delusions, were neglected for pathological reasons or were involved in parental symptomatology. Children brought up in a family with a schizophrenic parent may experience chaotic situations during their formative years due to the bizarre symptoms (e.g., hallucination, delusion, thought disorder, persecutory idea and so on) of their psychotic parents. Their mentally ill parent's frequent hospitalization and the overburden of their another parent may also disrupt the family routine and create a stressful emotional climate in the family which may be harmful to physical and mental health of the family members.

Schizophrenia is usually manifested by odd or inappropriate social behavior which are restless and unpredictable at times. The children may experience social stigma and tremendous stress when their schizophrenic parents show actively disturbing and socially embarrassing behavior in public, and exhibit aggression, violence or self-destructive behavior. Clausen and Huffine (1979) stated that a parent who had a diagnosis of schizophrenia might cause special

problems in family because of his/her mood and behavior. Some schizophrenics even have marked impairment in role functioning, personal hygiene and grooming. Instead of a supportive figure, they become a heavy burden to their children.

In the light of the above studies, it is found that children of schizophrenic patients are indeed influenced by the behaviors and symptoms (including the withdrawal, negligence and acting out behavior) of their parents. They are also exposed to a handful of objective stressors and feel stressful because of the patients' socially unacceptable, embarrassing or disturbing behavior, impairment of role functioning and the problems in communication. Based on the available findings, it is reasonable to expect that children of schizophrenic patients may be exposed to objective stressors in the psychological, social and behavioural aspects.

2.3.2 *Impairment of interaction*

Problems of parent-child communication were reported more often in families of schizophrenics than in those of patients with other diagnoses (Clausen & Huffine, 1979). Since parents usually play the major role in the children's proper development of communication skills which are basic for gratifying social interaction, patients with schizophrenia and poor social skills may have difficulties in acting as

models for the children in performing socially acceptable behavior and in the appropriate and effective methods of expressing thoughts and feelings. As parental tasks/functions should include provision of emotional support for the children, warm parent-child interaction is of paramount importance to the child's personality growth. Since social withdrawal, incongruity and blunting of affect are common among schizophrenics, they may exhibit lack of initiative, interest, or energy. Consequently, their interaction with other family members, including their children may be minimal. Systems theory suggested that physical, social and emotional functioning of family members are basically interdependent. With changes in one part of the system, the other parts of the system would be affected. As family interaction and relationship tend to be highly reciprocal (Seligman & Darling, 1989), impairment of parent-child interaction may have different impacts on the children's behavior, emotions and personality development. Social learning theory has also explained how relationship deficits may interfere with the development of competence in children (Bandura, 1986; Coyne, 1976).

2.4 Parents with depression versus parents with schizophrenia: their differential impacts on children

2.4.1 Parenting

Many studies have indicated that mental illness influences parenting style which is in turn correlated with the child's mental health.

Gizynaski (1985) proposed that maternal behavior may be unassertive and not effective when the depressed mother has a reduced sense of esteem and effectiveness, which is likely to lead to low expectations of control over the child's behavior. It was also found that stress and depression reduced a mother's tolerance for her child's maladaptive behavior and this could lead to both negative reaction and withdrawal. As a result, the mother may be hostile and uninvolved; and they may find it difficult to generate effective problem-solving strategies with their children in conflictual situations (Grunebaum, Cohler, Kauffman & Gallant, 1978). Goodman and Brumley (1990) depicted that schizophrenia might influence parenting because a) the schizophrenic patient might be withdrawn and passively interacted with the environment, which presumably includes the child; b) delusion might involve the child; and c) the child would be exposed to the incongruent affect which were often associated with schizophrenic parents. Moreover, social skills deficits prevented schizophrenics from successfully engaging in tasks such as interacting in social situations, self-managing their illness, participating in recreational activities, managing finances, performing basic self-care and practicing effective parenting (Garmezy, 1974). The schizophrenic parents might adopt an "indifferent" parenting style (Baumrind, 1983) as they might not be conscious to set limits for the children either because they just didn't care or because they were pre-occupied by delusional thoughts. They

therefore did not have enough energy left over to produce guidance for their children.

2.4.2 *Children at risk*

Research on depressed parents indicates that their children are at risk for depressive disorders as well as for impairment on the other emotional, somatic, and behavioural aspects of adjustment. Since most schizophrenic patients have a frank depressive episode at some periods in their illness, it is interesting to ask if their children might also experience similar impact as the children of depressive parents.

However, some studies indicated that the impact of schizophrenic parent on children was even greater than that of depressive parent since parents with schizophrenia might have even poorer quality interactions with their children and provide a less adequate child-rearing environment than depressed parent (Goodman & Brumley, 1990). The cognitive deficit in depression may be different from and less severe than that in schizophrenia. Depressive parents are more likely to understand the demands of the situation while the schizophrenic parents are withdrawn and emotionally uninvolved. Some researchers found that among vulnerable children in grade schools, children of schizophrenic mothers displayed poorer school and peer adjustment than

neurotic children, children of depressive mothers, or control group children (Grunebaum, Cohler, Kauffman & Gallant, 1978).

In a study of 73 children of both mentally ill and mentally healthy parents, children of schizophrenic parents performed more poorly on the neurobehavioural tests than the children of parents with other psychiatric disorders or those with no history of mental illness; and sons of schizophrenic parents were rated to be more withdrawn than the other children in the study. It was also found that the children of schizophrenics showed a considerable incidence of social and psychological maladjustment (Auerbach, Hans & Marcus, 1993).

In a community survey, Gibbons and associates (1984) found that family members of schizophrenic patients experienced more distress in the first five years following the diagnosis of schizophrenia. When the characteristics of the schizophrenics changed and negative behaviors such as withdrawal, self-neglect, and underactivity became more evident after five years, it was found that 63 percent of the patients whose children under 16 showed emotional or physical ill health or conduct problems (Gibbons, Horn, Powell, & Gibbons, 1984).

Clausen and Huffine (1979) stated that children of schizophrenic parents manifested more problems than those of parents with affective

psychoses and neurosis in a number of aspects. These problems might be due to genetic vulnerability, nature of the parental personalities and the marital relationship itself or lesser parental care and affection. In their study, children of schizophrenic parents tended to respond somewhat differently to the problems of their families than did children of parents with other diagnoses. For example, many children of schizophrenic mothers were less concentrated on their schoolwork than the children of patients with affective diagnoses. In the same study, it was also found that serious problems (e.g., psychotic episode, psychiatric treatment and severe emotional problems) were more frequently reported for children of schizophrenic female patients than for any other category.

2.4.3 *Problems faced by the children*

Problems of parent-child communication were reported more often in families of schizophrenics than in those of patients with other diagnoses (Clausen & Huffine, 1979). Parents with schizophrenia may have different features from those with depression or affective disorder though many schizophrenics also experience some depressive episodes in their lives. Long term impairments of schizophrenics can be very distressing both for the patients who may experience loss of functioning and for the family members.

Schizophrenic patients, who have persistent impairments, very often have a major influence on social functioning and ability to achieve life goals. Impairments such as loss of pleasure in relationships and difficulty in conversing can result in the characteristics of becoming socially withdrawn. Such impact of impairments of schizophrenic parents on the adolescent children may be devastating. In addition to the extra burden placed on them by having to be more active and make more decisions themselves to compensate for their impaired parent, the emotional impact can be overwhelming. Fadden, Bebbington, & Kuipers (1987) stated that families were often much more distressed by their relatives' all-pervasive low mood and loss of drive than by their bizarre or disturbed behavior. Similarly, Creer and Wing (1974) reported that the most frequent problems of schizophrenic patients living with families in their sample were for the management of negative symptoms and difficulties in coping with social performance.

The above findings indicated that children of schizophrenic patients seem to be more at risk to the problems of emotional and somatic disturbance, school and peer adjustment, conduct and schoolwork problems, genetic vulnerability, lesser parental care, or even psychopathology. Moreover, the above studies seemed to delineate mainly the relationships between parental schizophrenia and children's psychological, social and behavioural problems. They had not further

explored other aspects of the problems, such as the relationship between a specific parental behavior and its impact on children, parent-child interaction, family environment, social and psychological resources of the family and the individuals as well.

2.5 Discussion on the above findings

Based on the existing literature on the impact of parental depression or schizophrenia on children's mental health, it can be observed that (i) children of disturbed parents may have difficulties in the social interactions with their parents, deeming them unrewarding and resulting in a sense of failure in the relationship; (ii) parenting by disturbed parents seems to be less reciprocal and less responsive. They appear not as involved as the "normal" parents nor do they provide as much structure or discipline to the children as other parents do; and (iii) the parenting practice may also account for the children's social competence and for the transmission of psychopathology from parent to child. The above studies, without exploring the personal and social resources of those "at-risk" children, suggest that children of mental patients are always facing poor parenting and unsatisfactory parent-child interaction which in turn may affect their mental health.

In fact, from the author's observation in the clinical settings, the above negative impacts on the children were found in some cases

though it was doubted if the "transmission of psychopathology" could simply occur between the parent and child. It was found that mentally ill parents with diagnosis of depression or schizophrenia were not necessarily passive, socially withdrawn, poor in general functioning or negligent to their children; and their children were not necessarily having psychopathology despite their adversities in the family. There may be some other personal and social factors which were predictive of the children's perception of stress and their psychological well-being.

Some studies had shown that mental health of those "vulnerable" children were subject to multiple factors. One of the very few studies to assess the long-term impact of parental mental illness on the development of children was a fifteen year follow-up of children of schizophrenic mothers by Miller, Challas and Gee (1972). The investigators concluded that the children of schizophrenic mothers differed little in developmental deviance from children of other lower-class families. This study emphasized the importance of the resources available to the family in determining outcomes for the children. Rutter and Quinton (1984) suggested that children who were exposed to violence and conflicts between parents or those became involved in a parent's delusional ideas were vulnerable to develop psychological difficulties, regardless of the parent's diagnosis. The difficulties faced by the children of psychotic parents also correlated with whether the

normal parents were able to be supportive and understanding or whether the marital conflicts existed (Clausen & Huffine, 1979). Some other studies indicated that factors such as family life might aggravate or ameliorate the genetic risks of schizophrenia (Webster, 1992). In fact, from the author's experience in working with the adolescent children of the schizophrenic parents, they were more likely to experience stress in the situations during parental conflicts or lack of parent-child communication which were prevalent in the families of mental patients. Moreover, those children who were optimistic and sociable appeared to be more capable of facing and managing strains in the family and had more acceptance to their mentally ill parent.

In view of the above findings, whether the schizophrenic parents would cause aversive impacts on the children might depend on many other psycho-social factors. The children's personal characteristics and ways of coping play an important role in determining the impact of their schizophrenic parents on the children themselves. Rutter (1985) stated that coping mechanisms might be developed from the developmental stage of the child when he/she was exposed to the stress, as well as from the child's reactions to previous stressful events, the experience of having positive relationship in the past, and the child's personal resources which includes cognitive attitudes and temperament. The severity or the frequency of stressors in the family, the coping resources,

social relationships, social support, family life or parenting style are the main factors influencing the mental health of the children and are worthwhile to explore.

2.6 *Resilience in children / adolescents*

Although there were many studies about children / adolescents under stress (Berlinsky & Biller, 1982; Rutter & Quinton, 1981), it was found from studies that some children could be remarkably resilient to stress (Felsman & Vaillant, 1987; Garmezy, 1983; Werner & Smith, 1992).

In a study of the stress of children who were brought up with a psychotic patient, Anthony (1987) recognized that even within one family the children might vary markedly in their vulnerability or resilience. From the author's clinical experience, the resilient children / adolescents were often found to have a "sunny" disposition. They liked to laugh, had a sense of humor, appeared to be initiative and sociable, and moreover, they had more acceptance to their parents and family environment. Other studies also showed that a large proportion of stressed children, including children of schizophrenic parents (Masten, Best, & Garmezy, 1990), did very well in different aspects of life and they had similar factors which buffered the effects of stress which were

cognitive skills, temperament, and social integration (Garmezy & Masten, 1986).

Some other studies illustrated that more intelligent children might function well at school, which enhanced their sense of achievement and self-esteem that could buffer other stressors (Anthony, 1987). Wolin and Wolin (1993) also observed that resilient children had good insight that they understood the parent was troubled and that the parent's behavior was not the child's fault. They also had good relationships because they were capable of cultivating positive interactions with others. Moreover, resilient children were often found to have optimistic temperament (Garmezy, 1983). Such children might be more ready to face stress and stay away from mental health problems. Some studies also reported that such children had higher level of self-esteem and self-efficacy (Cowen, Wyman, Work & Parker, 1990). Actually, such children / adolescents were more likely to have positive social interaction with others, which in turn would enhance their resilience. In this study, self-esteem and self-efficacy of adolescents would be studied to see if these attributes have relationship with stress and maintain better mental health.

2.7 Limitations of some empirical studies about children of mentally ill

Goodman and Brumley (1990) studied 53 schizophrenic and 25 depressive patients. They found that the mother's parenting practices, and not her diagnosis accounted for much of children's social competence. They used the findings to support the interactional model for transmission of psychopathology from mother to child. Their study not only focused on the parental mental illness on the children, but also contributed to explore the quality interactions with their children and child-rearing environment. However, sampling bias existed in their study because the sample was predominantly Black (90%), low income (90%) and single-parent mother (90%). Due to the respondents' disadvantageous race, marital and socioeconomic status, the stressors they faced and the parenting style would be different to a certain extent. Therefore, the findings needed to be replicated with other similar and different populations. Moreover, the mother-child interactions were studied for only 5 - 30 minutes in an office setting, it would be difficult for the mother and child to feel comfortable with such process. A longer observation or more casual environment were needed if more representative and generalized findings had to be yielded.

Rutter and Quinton (1984) conducted a study of 137 psychiatric patients' families with children under 15 years old. It was a

comprehensive and intensive study that detailed standardized interviews were undertaken yearly with parent-patients and with their spouses. Moreover, a comparison was made with a control group of families in the general population with 10-year-old children. Besides, a classroom comparison group was also formed. Over the 4 years of the prospective study, class teachers completed questionnaires yearly on these children, as well as on the children of patients. This longitudinal research studied the time relationships between remissions and relapses in the parents' mental illness and the course of psychiatric disorder in the children. The results indicated that patients' families differed in terms of a higher rate of psychiatric disorder in spouses and a much higher level of family discord. According to the data, it was also found that children of psychiatric patients had an increased rate of persistent emotional/behavioral disturbance when parents' personality disorders associated with hostile behavior.

This study threw light to the importance of making an assessment of personality functioning as well as the presenting psychiatric disorder. As shown by the results, it was illustrated that no close connections between the parental symptoms and the course of disorder in the children existed. The researchers attempted to depict that parental hostility and aggression were more important than psychiatric symptoms. However, it was doubted that if it was proper to assume that

discord constituted the only operative mechanism. Moreover, the report and discussion had not calibrated the findings by reference to general population because no parallel study of a non-patient control group was undertaken. It seemed that the comparison groups were not fully utilized.

Further analysis of the study also revealed that discord was the main factor associating parental mental illness and conduct disturbance in the children. However, the impact to the schizophrenics' children were excluded in the findings. In fact, the sample included too few schizophrenic patients (only 10 over 137) which would probably cause the sampling bias, low generalizability and representativeness.

From the above studies, it might be concluded that limitations did exist, but they still had their contribution in terms of their specific perspectives which gave us more understanding about the impact of parental mental illness on the children. Nevertheless, the studies about the stress, coping resources and mental health of the children of the mentally ill were rare. The author would place emphasis on these concepts in the next chapter.

Chapter Three

Stress, Coping Resources and Mental Health

The concepts of *stress* were reported in Section 3.1 to 3.5. The topic of stress and coping in children / adolescents would be put in Section 3.6. Coping resources, and the conceptions of *self-efficacy, self-esteem, knowledge about schizophrenia and attitude toward ex-mental patients* would be presented in Section 3.7 and 3.8 respectively; and the construct of *self-efficacy*, which was rarely studied in the local context, would be elaborated in more details in Section 3.8.1. The concept of *mental health* in terms of psychiatric morbidity and hopelessness would be covered in Section 3.9.

3.1 Concept of Stress

The obstacle in conducting an enquiry into stress-coping phenomena might be the absence of an adequate, universally accepted definition of stress. In the past, some definitions /conceptualizations had been used. Rutter (1983) observed that "stress seems to apply equally to a form of stimulus (or stressor), a force requiring change of adaptation (strain), a mental state (distress), and a form of bodily reaction or response". Cox (1978) defined stress in terms of the response-based, stimulus-based and interaction-based conception.

In this study, the definition of stress was **stimulus-based** and the conception of "**stressors**" was employed. "**Stressors**" might be further categorized into ***life events, daily hassles and life strains / burdens*** among which the author selected life strains to delineate the concepts of stress. Under the conception of "***life strains***", "***subjective / objective burdens***" would be further elaborated by ***management problems, psychological problems and social / economic costs*** encountered by the adolescent children of schizophrenic patients.

Table A showed that the definition of stress was delineated in terms of the following conceptions:

1. ***Response-based conception***

Selye (1974) described stress as the "non-specific" response of the body to any demand made upon it. He interpreted stress as a fairly predictable constellation of psychophysiological responses to stressors in his "General Adaptation Syndrome" which consisted of three stages. These three stages were 1) the Alarm Stage, in which adaptation was not yet been acquired; 2) the Stage of Resistance, in which adaptation was optimal; and 3) the Stage of Exhaustion, in which the acquired adaptation was lost again. Stephan (1971) also described stress as the physical or mental effect or disturbance of, or interference with, any of the body's automatic biological processes.

2. ***Transaction-based conception***

Based on the ecological model, Cox (1978) also depicted that stress was a complex and dynamic system of transaction between the person and his environment. He further stated that stress was an individual perceptual phenomenon rooted in psychological process. Caplan (1976) linked the concept of stress with health and viewed that stress was a condition in which a discrepancy existed between the environmental demands, loss, threatened loss, or life events and the individual's capacity to respond, thus threatening conditions essential to health. Novaco (1980) emphasized the role of the perceived environmental demand and the individual's perception of threat that must be determined in order to evaluate the potential adverse effect. Lazarus's transaction theory (1966) also proposed that an individual's response to stressful events was mediated by cognitive appraisal and coping.

3. ***Stimulus-based conception***

Holmes and Rahe (1967) devised the Social Readjustment Rating Scale to examine the impacts of life changes. "***Stimulus***" might be delineated through the conceptions of ***stressors*** which referred to the experiential or objective circumstances that gave rise to stress. Acute stressors resulted from experiencing a number of threatening situations and chronic stressors resulted from persistent and excessive demand on individual.

In **Table B**, the concepts of stimulus were depicted through the conceptions of life events, daily hassles and life strains (burdens).

1. ***Life events***

There were some stressors occurring in daily living which could affect one's life and well-being. They were objective threatening experience (Holmes & Rahe, 1967), factors causing disease (Wolff, 1950), suicide or schizophrenia (Paykel, 1974).

2. ***Daily Hassles***

Daily hassles referred to the conspicuous, daily and long-lasting problems, nuisances and incidents which threatened or harmed people's well-being (Lazarus, 1985; Pearlin, 1985). They might be chronic stressors (Cohen, 1985) and disadvantageous life circumstances (Eckenrode, 1984).

3. ***Life Strains***

Pearlin and Schooler (1978) identified four types of chronic strains. Pearlin (1989) categorized life strains into daily events, predictable events and unscheduled events. Pearlin (1985) also proposed these types of strains within the boundaries of major social roles and role sets. Instead of conceptualizing chronic strains in terms of role strains, Noh and Turner (1987) viewed them as continuing burden generated from specific source of environmental conditions. Based on the idea of Hoeing and Hamilton (1969), Noh and Turner identified two types of burdens, i.e. "objective burden" and "subjective burden" relating to the care of the mentally ill. The concepts of burdens would be further elaborated in the later sessions.

Table A **Concepts of stress**

Nature of stress	Emphasis of content
1. ***Response***	• non-specific ***response of body*** to any demand made upon it. • predictive, ***psychophysiological response*** ---- General Adaptational Syndrome (Selye, 1974). • ***physical or mental effect or disturbance*** of the body's automatic biological processes (Stephen, 1971).
2. ***Transaction***	• complex and dynamic system of transaction between the ***person*** and his ***environment*** (Cox, 1978). • discrepancy existed between ***environmental demand*** and ***individual capacity*** to respond (Caplan, 1981). • imbalance between ***perceived demand*** and ***person's perception of capacity*** to meet that demand (Novaco, 1980). • particular relationship between the ***person*** and the ***environment*** that was appraised as exceeding individual resources of the social system (Lazarus, 1966).
3. ***Stimulus***	• resulting from experiencing a number of situations, that were threatening (***acute stressor***) or that had excessive demand on individual (***chronic stressors***).

Table B **Concepts of Stressors**

Stressors	Special properties
1. ***Life Events***	• ***objective experiences*** that ***disrupt*** or threaten to disrupt one's activities, leading to some extent of readjustment in one's behaviour (Holmes & Rahe, 1967). • involve ***threat*** which led to increase in the risk of suicide and schizophrenia (Paykel, 1974). • caused difficulties in people's lives and were factors in the ***etiology of disease*** (Wolff, 1950).
2. ***Daily Hassles***	• long-term ***social and economic stimulus*** of stress, ***long-lasting*** problems, threats and conflicts that one faces daily (Pearlin, 1985). • ***chronic stressors*** which might not necessarily be caused by discrete events (Cohen, 1985). • relatively stable, ***continuing and disadvantageous life circumstances*** such as low income, poor education, overcrowding housing condition (Eckenrode, 1984).
3. ***Life Strains (Burdens)***	• ***marital, parental, economic and occupational strains*** are four types of chronic life strains (Pearlin & Schooler, 1978). • divided into three categories that might elicit emotional distress which include 1) ***daily events***; 2) ***predictable events***; and 3) ***unscheduled events*** (Pearlin, 1989). • role ***overload***, interpersonal role ***conflicts***, and role ***restructuring*** . • ***objective burden*** (e.g. effects on health, financial loss) & ***subjective burden*** (the extent to which relatives felt they carried a burden) (Hoeing & Hamilton, 1969). • focused on specific type of ***environmental conditions*** that caused ongoing stressful experience (Noh & Turner, 1987).

3.2 Life events, daily hassles and life strains

Although ***life events*** were accepted as important factors in the etiology of disease since early years (Wolff, 1950), some studies pointed out that the relationship between life events and psychological (or physical) disorder had been unexpectedly low. Moreover, it was considered that defining stress as major life event would limit the concept and overlook a large constellation of factors that affect health and adaptation. ***Daily Hassles*** were considered as less dramatic but were more ordinary disadvantageous circumstance, more affected by cognitive appraisal, more important in adaptation, and appear to be better predictors of health than major life events. ***Life strains*** were usually considered as specific type of stressful environmental condition. In the context of this study, strains were further elaborated through the concepts of burdens. Although the onset, relapse and hospitalization of schizophrenic patients might be considered as stressful life events in the family, life events would not be examined in this study since the family members of the mentally ill were facing continuous and durable pressure stemmed from the social, emotional, physical and financial strains (Atkinson, 1986; Noh & Turner, 1987). Moreover, the family members of mentally ill might experience role strains as a consequence of the financial / employment problems or disruption of household routine (Birchwood and Smith, 1987). The concept of strain/ burden was therefore used to depict "stress" in this study. To delineate the specific

strains in the family of schizophrenics, the concepts of objective and subjective burdens were employed.

3.3 Objective burden and subjective burden arising from the mentally ill in the family

Hoeing and Hamilton (1969) had made the distinction between objective burden (e.g. effects on health and financial loss) and subjective burden (the extent to which relatives felt they carried a burden). In the studies of care for the mentally ill, Noh and Turner (1987) suggested that the families of mental patients tended to experience chronic strain to a certain extent. In their study, chronic strain was discussed in terms of objective burden and subjective burden. Objective burden referred to concrete problems such as financial difficulties, disrupted social life and family functioning whereas subjective burden referred to the patient's presence, behaviour and/or dependency which were perceived as causing worries and strains in the family. They found that the common problem of the family members of the mental patients was the psychological distress they experienced which in turn affected their mental health. However, the family burden might not be the most important correlate of the mental health of family members. They observed that the social-psychological variables such as social support and sense of mastery other than family burden were more significantly

associated with the level of mental health (Noh & Turner, 1987). There were research findings indicating that perceived stress was a more powerful predictor of health status than objective stressors (Cohen, 1985; Lazarus & Folkman, 1984).

Wong (1991) also examined chronic strains of the caregivers of schizophrenic patients. He equated objective burdens as chronic stressors and subjective burdens as perceived stress. Both the chronic stressors and perceived stress were suggested to be related to (i) management problems (i.e., difficulties in managing problematic behaviors); and (ii) social and emotional costs which included financial and relationship problems. Both the objective burden and subjective burden were conceptualized to be a bit different in the study of Sun (1994) who defined objective burden as the adverse effect on the household, health and disruption of life; as for subjective burden, instead of depicting perceived stress which was stemmed from the objective stressors, he emphasized the specific psychological impact such as the sense of loss, grief, guilt and anxiety.

In this study, similar to the idea of Wong's (1991) study, the objective stressors included the management problems and social costs. Additionally, the specific psychological problems would be examined as part of the stressors. The subjective burden would be construed in term

of perceived stress which was corresponding to the specific objective stressors.

3.4 Stressors as management problems, psychological problems and social / economic costs faced by the children

Upon reviewing the studies about the chronic strains specifically exist in the family of schizophrenic patients, the author borrowed the concepts of Creer and Wing (1974), Grad and Sainbury (1963), Hatfield (1978), Noh and Turner (1987), Torrey (1988), and Wong (1991) to categorize the stressors exposed to the adolescent children of schizophrenic parents in the family. Generally speaking, it was proposed that the chronic strains facing the adolescent children of schizophrenic parents may be classified as: (a) management problems, (b) psychological problems and (c) social / economic costs.

3.4.1 *Management problems*

Grad and Sainbury (1963) assessed the effects of the patient's illness on the family and found that at least one-fifth of the families had severe management problems. They found that 61% of the families had to handle hardship at home as a consequence of living with a patient. The family members of the mental patients reported to experience stress due to *upsets of domestic routine, being bothered by patients' somatic complaints, suicidal attempts and income reduction.*

Creer and Wing (1974) reported that family members of schizophrenic patients considered the negative symptoms, such as *social withdrawal, lack of conversation, underactivity, slowness and having no leisure interests*, most problematic. The other group of negative symptoms were *socially embarrassing behaviors and the more obviously disturbed behaviors.*

Similarly, Vaughn (1977) showed that family members were more capable of tolerating patients' positive/first rank symptoms (including delusional perception, thought disorder and hallucination); on the other hand, *the negative/non-first rank symptoms of schizophrenia (including marked apathy, paucity of speech, blunting or incongruity of emotional responses and social withdrawal* were found to be most difficult to cope. He reported that one-third of the respondents' remarks concerned positive symptoms while two-thirds referred to *behavior such as lack of communication, affection, interest and initiative.*

Other researchers also found that *administration of medication, disturbances at home, and to neighbors, threat or actual harm to others* were burdensome problems (Wing, 1988; Test, 1981). In the local studies, Chan (1993) found that most of the caregivers had the burdens of *financial problem and disturbance of domestic routines*.

In short, an integration of the available studies show that the management problems faced by the relatives of schizophrenics might include the *management of patient's symptoms, medication compliance, and residual symptoms like personal hygiene, poor volition, poor budgeting, neglect of appearance, social withdrawal, underactivity, lack of conversation, few leisure interests, heavy smoking, abuse of alcohol, overactivities, odd ideas, odd postures and movements, threat of violence, depression, and also bizarre, anti-social, aggressive, suicidal or self-destructive behaviors.*

3.4.2 *Psychological problems*

One of the findings of Birchwood and Smith's (1987) study about the consequence of schizophrenia for the family life was the emotional changes of the family members. Negative emotions such as *guilt, fear, embarrassment and anger* emerged due to the tense family-patient relationship, conflictual family relationships and tangible hardship. Another local study (Lieh-Mak & Pan, 1987) also showed that many relatives of schizophrenic patients suffered from emotional disturbances. How about the children of schizophrenic parents? From the findings of studies presented in Chapter 2, it was speculated that children of the mental patients might also experience emotional trauma. In fact, emotions such as *anger, fear, shame, guilt and depression* are not

uncommon. Major questions may arise, such as "Will I become mentally ill like my parent? Will my children become mentally ill?" Whether spoken or unspoken, conscious or unconscious, these serious concerns create an undertone of *anxiety and insecurity.*

Children of schizophrenic patients may be suffering from different strains. The family pain may lead to more discouragement and bitterness. When there is a lack of honest discussion of the painful feelings among family members, further distress in children may be created. Being unable to talk about the range and intensity of emotions they feel, children may have difficulty in getting on with their own lives. In these instances, it is only when the feelings related to their parents' illness are acknowledged, accepted and understood that children may once again begin charting their own course in life. The negative emotions in children with schizophrenic patients may include the following:

(a) ***Self-blame and Guilt***

Adolescent children of schizophrenic patients do, of course, have negative feelings, many of which are difficult to bear. However, other people may not know about their plights and difficulties if they do not voice them out. The children may wonder "Does enjoying my life while a parent suffers this tragic illness make me a bad person?" "Do I cause

my parent's relapse?" These sorts of thoughts may be denied and unconscious. They may also ask, "What are my family obligations to my parent?" "Should I be my parent's keeper?" If the children are always pressed by guilt feelings, they may find various physical or emotional problems in other parts of their lives.

Adolescent children sometimes wonder if they somehow should be responsible for the unstable mental state of their ill parents or failure to detect the early warnings and prevent it. They may have resentment toward their ill parent for disrupting family routine and their social life, but they may have guilt about such negative feelings. On the other hand, they may have guilt for not feeling guilty enough.

(b) ***Anger***

There can be anger at the loss of a valued protector and guardian. They may wonder "Why me? Why is my parent in chaos?" They may have grievance for taking up more household tasks within the family. They may also have anger toward their ill parents' aggression, temper outburst, threat or actual violence. Their anger may also be caused by frustration, by the sense of powerlessness in helping the ill parent and by the feeling of unfairness. Moreover, the adolescent child may be angry at the other parent or other family members for the way they are

handling the illness. Anger may be directed toward family members, toward oneself or toward the ill parent, as well as other professionals.

(c) ***Feeling of Embarrassment and shame***

Another common aspect of children's stress is a feeling of embarrassment or shame when their parents are present in social gatherings either within or outside the family. In fact, many schizophrenic patients appear to be self-absorbed and socially withdrawn. The children may feel "different" and embarrassed as their parents act in unusual ways especially in public places. However, some of the children may respond by asserting that nothing is wrong with his or her parent as a person. In working with such children, it was found that their wish to support and include their schizophrenic parents may be mixed with a feeling of confused filial piety or loyalty and social discomfort. An adolescent child may ask himself or herself, "Will my friends laugh at me?" or "What will they think of me when they find out that I have a schizophrenic parent?"

(d) ***Anxieties caused by parent's hospitalization***

Even though the ill parent may have been involved with psychiatrists and other helping professionals before, the hospitalization, particularly to a closed ward, can be disturbing to the adolescent children. Usually, they do not understand mental illness. In addition,

the experience of being "locked" in the ward when visiting may cause fears. Other patients may appear bizarre or out of touch of reality. The children may become anxious about the welfare of their parents, who are surrounded by other patients. In fact, the living condition of mental hospitals is still considered to be overcrowded and below satisfactory in Hong Kong.

Women who took children to visit their hospitalized fathers more often reported that children were apprehensive or nervous (Clausen & Huffine, 1979). The children may wonder if this will be their fate --- to go crazy and be hospitalized. Also, there can be many mixed feelings concerning the justice or injustice of involuntary hospitalization, especially when the patient's compulsory hospitalization is assisted by police. Some people may consider being hospitalized in mental hospital as one of the oppression and incarceration rather than of healing and nurturing. Seeing one's parent sedated on heavy doses of medication, the children may evoke *concern, sorrow and feelings of helplessness.*

The hospitalization of the patient may shake a family's self-image. Given the stigma of mental illness and the public's vast misunderstanding about the nature of mental illness and ex-mental patients in Hong Kong, family members may feel ashamed of having a

schizophrenic member. Children can be profoundly affected by these difficult emotional currents within the family. Anxieties, feelings of helplessness and confusion then become companions of children as well as another parent. During the patient's hospitalization, the adolescent children may have contact with the mental health professionals and some family members may feel guilty, ashamed, or confused. They may also experience the bureaucratic nature of the hospital system. After visiting the schizophrenic patient in the hospital, family members may feel that the mentally ill persons are not receiving the quality of care he or she deserves. Adolescent children may also feel that the needs of the family are being ignored as the professionals' attention merely focuses on the patient.

(e) Sense of inferiority caused by the prejudice and rejection of community

The prejudice and non-acceptance toward ex-mentally ill in the community are still very serious in Hong Kong. The tremendous rejection of the establishment of half-way houses, day training centers or social clubs by the residents in some neighborhoods are discouraging especially to the mental health service providers as well as the family members of mental patients. Under such a social discrimination, teenage children of patients may not be willing to disclose their family situation to others for fear that they would be looked down on and

rejected. A *sense of self-pity or inferiority* might be developed which would hinder their normal psychological development.

3.4.3 *Social / economic costs*

In a 2 to 4-year follow-up of 42 schizophrenic men, Waters and Northover (1992) reported that many of the patients caused moderate to severe hardship to their relatives in terms of *social embarrassment*, inconvenience, and behavior which *frightened* them or gave rise to tension in the family. These costs also included *disrupted family routines*, assumption of *more household tasks*, *reduction of social life*, *financial hardship, discord* among family members, and *complaints from neighbors*.

(a) *Disruption of family functioning*

Hoeing and Hamilton (1969) assessed the burdens which fell on the family with a schizophrenic member and the burdens could be categorized in four areas: effect on *family finance*; effect on *health of family members*; effect on *family strains*; and effect on *family routine*. In their study, it was found that the disruption of the lives of individual members was the highest area of burden, with 42 % of families with a schizophrenic patient being affected. Financial effects were the next most important group of burdens, followed by health problems and strains in family members.

Grad and Sainbury (1963) assessed the effects of the patient's illness on the family. The results showed that the patient's illness led to *disruption of the household routine*, effects on *social and leisure activities and employment* of other family members. It was found that at least one-fifth of the families had a *severe management problem.*

Atkinson (1986) stated that when the ill spouse was the husband, there might be a severe *financial impact* as well as devastating *psychological and emotional* ones. The wife might find that she had to bear the whole burden of child-rearing alone and that her ill husband might assume the role of another child within the family.

Creer, Sturt and Wykes (1982) asked the family members of the mentally ill patients to select "content", "resigned" or "dissatisfied" in four areas of patient's behavior: self-care; housework; management of money; and socially difficult behavior. The findings indicated that there was a significant association between providing a lot of support for the patient and *dissatisfaction* or *resignation* on the part of the relatives providing support. A local study also indicated that a large proportion of families with a schizophrenic patients had *unsatisfactory family functioning* (Sun, 1994).

(b) ***Conflict in the family***

The children's *relationships* with the other parent and among siblings may easily become *strained* as each family member manifests the stress of coping with the mental illness in the family. Confusion may cloud *communications,* particularly soon after the illness has appeared. Moreover, *contradictions* may invade the day-to-day conversations of some families.

The schizophrenic parent may aggravate the conflicts within the family which existed before the onset of the mental illness. *Grievance* and *discontent* can surface and create even greater conflicts between family members. In some cases handled by the author, it was found that family members sometimes "*scapegoat*" the patient — ignoring the patient, distancing themselves or mocking the patient and any family member who tried to help him/her. In some families where there was much *unexpressed anger and resentment*, different family members might find themselves taking sides "for" or "against" the ill member.

(c) ***Financial difficulties***

Some families of schizophrenic patients are suffering from financial hardship. Low family income may be a result of *the limited working capacity* of the patient. The family is probably supported by

another "normal" parent. If the schizophrenic parent is the father who is not gainfully employed, the mother, who has to take care of the household, can only take up part-time work or depend on the Comprehensive Social Security Scheme (CSSA). Under such circumstances, the adolescent children may be deprived of material and social needs due to the stringent financial condition of the family.

(d) *Reduction in social life*

The adolescent children may attend fewer social functions, gatherings or recreational activities. Their social life is restricted because of the *financial difficulties* and their extra burden in taking care of their ill parent or taking up too much household chore. Some of them may be ashamed of having a mentally ill parent and become socially withdrawn under the unfavorable effect of *social stigma*. As a consequence of sacrificing their social needs, some adolescent children's self-development during this critical stage may be affected to a certain extent.

3.5 Perceived Stress

In reaction to the parent's illness and its consequence, one child may become depressed, another anxious, and another may have a cluster of emotions. Still another child may respond as if there is little stress.

These differences suggest that they are perceiving their situations differently.

Lazarus and Folkman (1984) argued that what occurred in the environment was not so important as the individual's interpretation of the environment. Individual perception or cognitive appraisal is the key factor in the ecological and the interactional view of stress. In the transaction with the environment, a person appraises his circumstances by degree of stressfulness, the strength of the resources they may employ and the availability of resources to fit the stress-related demands. If he / she assesses that the outcome of the specific situation is unlikely to have loss of valued resources, because either the stressor is minor or their resources are particularly well suited to the particular stressor, they will not feel stressful.

In the previous review of the concepts of stressors, much emphasis has been put on the objective assessment of the environment and its possible influence on the children of the schizophrenic parents. It seems to assume that those stressors may cause management problems, psychological problems and social or economic costs. However, whether these stressors will have negative impact on the psychological well-being may not be simply assumed. Kobasa (1979) also argued that stressful events were not predictive of future

depression. Moreover, the intensity of the impact might also be related to some moderating variables.

The perception of stress is a function of cognitive appraisal which reflects ways of seeing the world and interpreting events. These cognitive orientations may be correlated with internal resources which may include hardiness (Kobasa, 1979), resourcefulness (Rosenbaum & Simira, 1986), sense of mastery and self-esteem (Pearlin et al., 1981). Wong (1991) explored the moderating effect of the sense of mastery on perceived stress, and found that interaction of mastery and perceived stress had significant impacts on mental health. From the above findings, it may be concluded that the individual perception of the meaning of the event or the stressfulness of the stimuli is the central axis of stress. Furthermore, the perceived stress better predicts the psychological well-being than the objective intensity of stressors (Lazarus and Folkman, 1984; Cohen, 1985; Atkinson, 1986).

3.5.1 *Measurement of perceived stress*

Some scales like the Perceived Stress Scale (Cohen, Kamarck and Mermelstein, 1983) and Global Assessment of Recent Stress Scale (Linn, 1985) had been developed to assess the level of perceived stress. In a local study, Wong (1991) also emphasized the importance of perceived stress. He used self-constructed scales of Itemized Perceived

Stress and Global Perceived Stress as the measurement tools. In this study, the degree of the perceived stress would be studied corresponding to the objective stressors which were obtained by the frequency of occurrence. Moreover, the perceived stress would be measured through the Perceived Stress Scale (PS-ALL) which could be divided into the sub-scales of *Management Problems, Psychological Problems and Social / Economic costs.* The nature of this scale would be further elaborated in Chapter 5.

3.6 Stress and coping in children / adolescents

3.6.1 *Research of stress and coping*

Much research on stress and stressors had been conducted, but less attention was paid to the processes of coping. Stress measurement among children/adolescents had generally followed adult models (Coddington, 1972). Traditionally, the emphasis had been on major events, but there was also some interest in children's daily hassles.

More research on children's coping skills had focused on responses to major traumatic events, such as illness, hospitalization, personal disaster, divorce of parents or death or illness in family members. Coping research among children/adolescents used to focus on responses of special populations experiencing major personal trauma and painful situations such as bereavement and loss. Masten (1985)

proposed that study of stress and coping in children must include a developmental perspective, including attention to age, gender, and cognitive and socioemotional maturity in the child's perception of stress.

Ryan (1988) argued that stressors identified by children/adolescents appeared to be hassles, rather than the discrete events. Miller and associates (Miller, Tobacyk, & Wilcox, 1985) tested hassles in adolescents. They administered the Hassle Scale (Kanner, Coyne, Schaefer & Lazarus, 1981) to thirty-eight teenagers, aged 15 -- 18. They found hassles to be negatively and significantly related to psychological and physical health. Compas, Davis, Forsythe, and Wagner (1987) developed similar hassles scales for adolescents. They noted that those adolescents who had behavioural or reported relationship problems gained high scores on negative daily stressors. DeMaio-Esteves (1990) also reported that hassles were negatively associated with perceived health status among adolescent girls.

Kanner and associates (1981) compared subjects of early adolescence from intact, blended, and single-parent families and found that only the frequency of hassles differed among groups. It was also noted that children from intact families were less likely to report peer problem and feeling incompetent in school..

Murphy and Moriarty (1976) conducted a longitudinal research concerning the stress, coping and adaptational process in 32 normal children/adolescents over a period of 15 years . Measurements included various psychological tests, behavioural observations and coping and vulnerability inventories. The study resulted in the Comprehensive Coping Inventory, but it was too complex since there were about one thousand measures and variables. They found that adolescents were more likely to turn to their friends and siblings for social support than to their parents. Moreover, they proposed that the difference between disturbed or unhealthy children and normal children was not the presence or absence of stress, but rather how problems were managed. McCubbin, Needle and Wilson (1985) also found that adolescents who had good family problem solving skills were less likely to engage in substance abuse in coping with stress.

The above studies revealed the importance of problem-solving skills in coping with stress and the need for exploration of coping strategies among children/adolescents. It appears that the research and instruments relating to children / adolescents and coping are still limited. There is much work to be done to refine concepts and develop effective and widely used measuring instruments. As there is no such study conducted in Hong Kong, it is worthwhile to explore stress-coping process in children / adolescents in future studies. In the present

research, the personal coping would be examined and the rationale would be elaborated in the later section.

3.7 Coping Resources

Lazarus (1966) defined coping as the problem solving efforts made by an individual when the demands of a given situation tax adaptive resources. Thus coping is a process by which people try to manage the perceived discrepancy between the demands made on them and their resources in a stressful situation.

Coping resources refer not to what people do, but what is available to them in developing their coping repertoires (Pearlin and Schooler, 1978). Coping resources, interacting with the person and the environment, influence the stress-coping process. Caplan (1981) introduced the concepts of internal resources that existed within the individual. These might include aspects of individual's personality and ways of looking at problems. External resources were those resources that came from outside the individual. These might include many aspects of social support, valued aspects of the physical environment and material resources that were available to the person.

According to Pearlin and Schooler (1978), coping resources could be categorized into (i) social coping resources which were drawn from the interpersonal networks and social support was the most remarkable one and (ii) psychological resources which were intrinsic to personal characteristics and were available within individuals at any time. These psychological resources include self-esteem, self denigration and mastery. Pearlin and Schooler (1978) looked at the relationship among mastery, self-esteem, coping and reduction of emotional distress in four role areas: household economics, job, parenting, and marriage. They suggested that resources were more helpful in sustaining people facing strains arising out of conditions over which they had little direct control. It was concluded that psychological resources were predictive of effective coping of stress and the outcome of mental health. The author was therefore interested to select these personal attributes for this study.

Folkman, Schaefer, and Lazarus (1979) proposed five categories of coping resources which were health/energy/morale, problem solving skills, social networks, utilitarian resources and general and specific beliefs. Lazarus and Folkman (1984) emphasized that resources were primarily properties of the person and they re-grouped the resources to be (1) health and energy (physical resource), (2) positive belief (psychological resource), (3) problem-solving, (4) social skills

(competencies) and (5) the environmental resources including material (utilitarian) resources and social support. The above coping resources, especially the "positive beliefs" which will be elaborated in more details, are delineated as follows:

3.7.1 *Health and energy*

The important role played by physical resource is evident in coping with stress and facilitating coping effort. A healthy person is easier to cope with stress than a person who is not feeling well.

3.7.2 *Positive beliefs*

Positive beliefs as a coping resource facilitate one to feel that outcomes are controllable and one has the ability to affect or achieve the outcomes. In the process of cognitive appraisal, beliefs determine "how things are" in the environment and the perception of the meaning depends on the beliefs. Beliefs about personal control are important to functioning and are related to the feeling of mastery, self-esteem and confidence (Pearlin & Schooler, 1978).

These beliefs might be generalized ways of thinking and situation-specific expectation. Rotter's (1966) concept of internal and external locus of control is an example of general beliefs about control. An internal locus of control refers to the belief that outcome is

contingent to one's own behavior, and external locus of control refers to the belief that luck and fate are determinants. Bandura's (1977) concept of self-efficacy includes outcome expectancy which refers to a person's belief that a given behavior will lead to certain outcome, and efficacy expectancy refers to a person's belief that he/she has the ability to execute the behavior and produce the outcome.

Religious belief is also a kind of existential belief and a source of coping resources intrinsic to a person which can regulate emotions. It can also affect one's appraisal of the stressors and extract meaning out of stressful experiences. A research found that belief in higher purpose enabled patients who had suffered from spinal cord injuries to look for and see some benefits in the painful experiences (Bulman & Wortman, 1977).

Beliefs are closely related to values and attitudes which are also an integral part of the resources. Personal resources such as control, self-esteem, and hope are all related to values which in turn influence one's attitude. In this study, the author will look into the attitude among the family members of the mentally ill which has not been explored in Hong Kong. It is worth studying because the attitude indeed represents the underlying values, acceptance and belief systems of the individuals.

Among the personal characteristics, the sense of control had been explored and examined in many studies of personal resources in the United States (Johnson & Sarason, 1978; Kobasa, Maddi & Courington, 1981; Sandler & Lakey, 1982; Lefcourt, Martin, & Selah, 1984). It seemed that Americans value the attribute of control. How about the values of Chinese? It is therefore interesting to study if Chinese treasure more about the personal resources of self-esteem, hope or resourcefulness due to cultural differences.

Very few available studies are about the positive belief of the young people in the local context. In a study of 224 Chinese adolescents, the effect of positive belief and sense of control was correlated and it was found that those who believed they could deal with various potential concerns adequately reported less problems, and they were more likely to give a favorable evaluation of themselves and perceived themselves to be in control (Leung, Salili & Baber, 1986). Chan (1989) also studied the adjustment correlates of locus of control among 94 Hong Kong Chinese undergraduates. He found that the subjects generally believed in the importance of luck and fate (external control) and it appeared consistent with traditional Chinese values which emphasized traditions of obedience, conformity and harmonious relationships. However, they also manifested a belief in internal control in specific domains of achievement and interpersonal relationships.

In this study, the author would emphasize on the personal attributes related to the positive beliefs. They were self-esteem and self-efficacy of the respondents, and their relationships with perceived stress and mental health would be delineated in the later sessions.

3.7.3 *Social Skills*

Social skills may facilitate social functioning in human adaptation and they are important coping resources. They refer to the ability to interact and communicate effectively in a socially acceptable manner. They also help solving problems relating to human interaction, enlisting social support and giving the person a sense of control in social encounters.

Social competence, social skills training especially assertiveness training, emphasizes self-expression in socially appropriate ways. It had been associated with various benefits for adolescents such as enhanced self-concept and improved locus of control and lowered self-abasement (Jackson, 1979). In this study, the importance of social skills is integrated into the concept of social self efficacy. According to Bandura (1977, 1986), people used symbols as internal models to guide their behavior and as a means for estimating outcomes of their actions. Thus, the relevant symbolic information is a kind of internal resources which can enact certain behavior in specific situations.

In studying the adolescent children of schizophrenic patients, the author has selected to examine personal resources of personality traits which may be the most robust of all resources. Moreover, some studies showed that social support had limited effect under chronic stressor conditions, and those who possessed strong personal resources such as sense of controllability and self-esteem would better utilize social support than those who lacked those personal resources (Hobfoll, 1988).

3.8 Coping resources being examined in this study

As Wong's (1991) study about caregivers of schizophrenics only briefly covered sense of mastery which was found to have significant relationship with mental health, the author further explored other coping resources which should not be ignored among the adolescent children of schizophrenic patients. Personal characteristics may be particularly valuable resources since they are like personal baggage and are part of a person. Therefore, they may be employed immediately. On the other hand, material resources or social support often require time and availability of that resource. In contrast, self-esteem, sense of mastery, and optimism / attitude may be utilized whenever the person needs them. Knowledge may be a resource which can lead to better condition, can increase power and confidence in taking risks, and enhance ability to plan in order to facilitate the gain of other resources (Hobfoll, 1988).

The 4 coping resources under study were ***social self-efficacy, self-esteem, knowledge about schizophrenia and attitude toward ex-mental patients***. Owing to the paucity of research on ***self-efficacy*** in Hong Kong, this construct would be elaborated in more details than other constructs in this study.

3.8.1 *Self-efficacy*

Self-efficacy is defined as a judgment as to how well one can execute a course of action required to deal with a prospective situation; and it may be defined as the conviction or belief that one can successfully execute the behaviours required to produce the outcomes one desires (Bandura, 1977).

In the Bandura's social learning view, behavioral change is mediated through cognitive processes, but the cognitive events are induced and altered most readily by experiences of mastery arising from successful performance. In recent years, Bandura (1986) had emphasized that the primary basis for meeting the performance standards did not come from the external environment but from within the individual. Once a person set goals for which to strive, he/she would have self-satisfaction only when he/she made reasonable progress to achieve these objectives. Accordingly, he may feel proud, competent, or "efficacious" when he succeeds, and he may feel anxious, guilty,

shameful or incompetent if his performances do not meet his/her self-imposed requirement. So cognitively based perceptions of competence or self-efficacy stemming from successes contribute in a major way to the maintenance of high performance standards. As such, our perceived self-efficacy may be more important than our actual accomplishments at determining our interests and objectives. Bandura (1986) suggested that each of us was constantly processing, evaluating and re-evaluating information about our strengths and weaknesses, thereby forming a unique pattern of self-perceived competencies. These perceptions of self-efficacy then affect the activities people choose to pursue (or to avoid), thus largely determining who they are and what they are likely to become.

The term self-efficacy is used to describe the extent to which individuals perceive themselves as being competent to perform behaviours well enough. It also determines whether they will try to cope with difficult situations. People fear and avoid threatening situations, so they believe themselves unable to handle, whereas they behave affirmatively when they judge themselves capable of handling situations successfully. Perceived self-efficacy does not only reduce anticipatory fears and inhibitions, but through expectations of eventual success, it affects coping efforts once they are initiated. Efficacy expectations determine how much effort people will put, and how long

they will persist in the face of obstacles and aversive experiences. The stronger the efficacy or mastery expectations, the more active the efforts. Those who give up prematurely will retain their self-debilitating expectations and fears for a long time. As a consequence, a failure identity will develop poor self-efficacy and the person will feel worthless. Much research has been conducted to examine the relationship between self-efficacy and psychological well being such as depression and adjustment (Cozzarelli, 1993; Kanfer & Zeiss, 1992). Although there is evidence that self-efficacy is significantly related to mental health, will it have the similar relationship in different stressful situations or in different age groups? That is why the author selects to examine this construct as a coping resource in this study.

Moreover, self-efficacy, as asserted by Bandura, had a distinct theoretical foundation. In Bandura's learning theory(1986), psychological functioning was explained in terms of a continuous reciprocal interaction of personal and environmental determinants. Unlike the early behaviorists, who maintained that the environment shaped the child and his/her behaviour, Bandura characterized a child's social development as a continuous reciprocal interaction between children and their environments. Moreover, Bandura asserted that human thought, affect, and behaviour could be markedly influenced by observation, as well as by direct experience. Therefore, the experience the children

gained from social interaction was crucial to their growth and development, and thus social self-efficacy had its prominent role in involving themselves in shaping the environments. Bandura (1977) also pointed out that people were not passive reactors to the environment, with no control over either it or themselves. On the contrary, humans had the ability to manipulate the environment, and by doing so were able to affect their own behaviour. Therefore, the self-regulatory processes assumed an important function to establish one's self-efficacy.

The development of self-efficacy had been investigated in young children (Bandura, 1986), and Ehrenberg, Cox, & Koopman (1991) had also empirically investigated this construct in adolescents. They found that *perception of self-efficacy* was critical to adolescent development, especially in areas such as *academic performance, social competence, career choice and physical confidence.* On the other hand, perceived inefficacy was both distressing and depressing, especially during the adolescent years, when the aim of development was toward independence and self-confidence. They suggested that depression in adolescence might be related to a general lack of self-efficacy, or related to deficits in specific areas of functioning where self-efficacy was critically important. In the local context, there was no research ever to study the concept of self-efficacy, but the similar construct, sense of mastery, had been explored by Wong (1991), and Shek and Tsang

(1993) who supported the role of mastery in moderating the impact of stress on mental health. In this study, the nature of social self-efficacy and its relationship with stress and mental health would be examined.

(a) *Self-efficacy as a coping resource*

Litt (1988) remarked that *perceived self-efficacy* was the construct which had been put forth as an influencing variable of stressful experience. In another study, Cunningham (1987) studied a group of cancer patients and found that the perceived self-efficacy, rather than a more global sense of control, affected adjustment. Cunningham, Lockwood and Cunnningham (1991) later suggested that the perceived self-efficacy was one of the determinants of mood and quality of life. Schiaffino and Revenson (1992) studied the role of self-efficacy in the adaptation to rheumatoid arthritis and confirmed its strong moderating effect. Bandura (1977) had emphasized the belief in self-efficacy as a resource that is critical in coping. He asserted that the level and strength of one's efficacy expectations for a particular behavior determined whether or not the behavior will be attempted, and the attitude one will hold toward the hardship. In this conceptualization, efficacy expectation affected one's perception and interpretation of aversive events. Therefore cognitive strategies designed to modify the aversiveness of an event should be effective to the extent that they enhanced efficacy expectations (Litt, 1988).

(b) ***Social self-efficacy***

Bandura (1977) suggested that self-efficacy was a critical mediator of personal action and behavior change. He asserted that those with a strong sense of efficacy exerted greater effort to master the task while individuals with low self-efficacy would experience serious doubts about their capabilities and tended to decrease their efforts or give up when they were challenged with obstacles, problems or failure.

The self-efficacy in establishing and maintaining personal relations have been suggested as an important component of social competence in adolescence (Connolly, 1989). El-kind (1989) also emphasized that perception of self-efficacy could be critical to adolescents, especially to academic performance and social competence. Social competence is considered as a multidimensional construct in which the satisfactory attainment of social goals in specific situations is influenced by social-cognitive skills, social behavior, and personal expectancies (Dodge & Murphy, 1984; Ford, 1982). Social self-efficacy, focusing on self-expectations for personal skill in performing the specific behaviours that underlie personal relationships, thus assumes a significant role in achieving social goals which is crucial to adolescent's growth. Lazarus (1966) noted that the more ambiguous were the stimulus cues concerning the nature of the confrontation, the

more important were general belief systems in determining the appraisal process. If the social situation is clearly defined, specific self-efficacy and outcome expectancies may play a powerful influencing role in stressful experience (Litt, 1988). As social competence has a role in mental health, social self-efficacy would vary with psychiatric status.

In line with the above studies, self-efficacy has an important function when one meets an ambiguous social situation. Social self-efficacy may reflect an adolescent's social competence and expectation of personal mastery of specific social tasks that will contribute to success in social relationships (Connolly, 1989). *Social self-efficacy* is selected by the author in this study due to the importance of social competence to the adolescents. Since the adolescent's positive social interaction with significant others like parents and peers is important for forming their self-evaluation (Juhasz, 1989), meaningful and satisfactory reciprocal relationship is crucial to the development of adolescents. Acock and Demo (1994) also observed that supportive peer relationships enhanced general adjustment and well-being. Hightower (1990), in a longitudinal study, also found that the existence of positive interpersonal skills in adolescence was related to better mental health at later life.

(c) Measurement of self-efficacy

Sherer and Adam (1983), basing on Bandura's (1977) theory of self-efficacy, constructed the *General Self-efficacy Scale* which was used to assess general expectancies of self-efficacy. It was followed by Tipton and Worthington (1984) that they developed *Generalized Self-Efficacy Scale (short-form)* to measure people's expectations on their competence across a broad range of situations which were challenging and required effort and perseverance.

Self-efficacy, being unlike the other dispositional factors which may apply across a wide variety of circumstances, is more event-specific. Therefore, self-efficacy may represent very specific beliefs about personal capacities. Feelings of efficacy is able to motivate effective coping behaviors that are targetted directly at the problem at hand. The nature of the concept of self-efficacy facilitates its measurement to be developed into different event-specific scales, like *Perceived Self-Efficacy Scale to Manage Pain and Perceived Mathematical Self-Efficacy. Social Self-efficacy* was developed by Wheeler and Ladd (1978) which was adopted by the author and translated into the Chinese version in this study.

3.8.2 ***Self-esteem***

The concept of self-efficacy differs from ***self-esteem*** since self-esteem focuses on ***self-worth*** rather than on performance (Bandura, 1986). The principle of reflected appraisal holds that people's feelings about themselves are strongly influenced by their judgment of what others think of them, and self-esteem is thus viewed as a *product of social interaction.*

Emphasizing self-worth, Coopersmith (1967) delineated two components of self-esteem which were: (1) *global or chronic self-esteem* which involved the relatively enduring perception of overall worth or competence that an individual had; (2) *situational self-esteem* which involved an individual's perception of worth or competence within the context of a specific task or setting.

In his study of an eight-year project on the antecedents and consequences of self-esteem, Coopersmith (1967) found that parental warmth, respectful treatment of children, and other expressions of concern for the child's well-being were all associated with the development of self-esteem (Coopersmith, 1967). Therefore it was suggested that parents who supported, were interested in, and expressed

warmth toward their children, tended to generate high levels of self-esteem in children (Demo, Small & Savin-Williams, 1987). Similarly, Rosenberg (1965) stated that individual with high self-esteem respected himself, considered himself worthy while low self-esteem implied self-rejection, self-dissatisfaction and self-contempt. In his findings, adolescents who reported close relationships with their fathers were much more likely to have higher self-esteem than those who reported more distant relationships.

With regard to the construct of self-esteem in the current study, it may also be studied as a coping resource instead of a measurement of mental health alone. DeLongis, Folkman, & Lazarus (1988) asserted that perceptions of self-esteem were also predictive of the effect of a stressor on ***well-being***. Hobfoll (1988) also emphasized that relationship between self-esteem and ***health.*** Those who were high in self-esteem exhibited better ***mood, health*** and ***psychological well-being*** in the face of stress. According to Greenberg and associates (1992), self-esteem was related to stress and it was a kind of psychological buffers and stress-coping mediating factors (Greenberg, Pyszczynski, Burling, Simon, Solomon, Rosenblatt, Lyon & Pinel, 1992). Self-esteem was also a central psychological mechanism for protecting individuals from anxiety (Greenberg, et al., 1992). In the local context, Chan and Lee (1993) studied over 1,000 Chinese adolescents with Chinese version of

the Self-Esteem Inventory and the General Health Questionnaire. Self-esteem was found to relate substantially to general psychological symptoms and particularly to specific symptoms of anxiety, social dysfunction and depression.

(a) ***Measurement of Self-esteem***

Self-esteem is usually measured by *self-report* instruments. For children, the Piers and Harris Children's Self-Concept Scale can be used (Piers & Harris, 1984). Other common scales are *Coopersmith Self-Esteem Inventory* (Coopersmith, 1967), and *Rosenberg 's (1965) Self-Esteem Scale.*

3.8.3 *Knowledge / Information*

Lazarus and Launier (1978) had proposed that the coping modes were subdivided into information-seeking, direct action, inhibition of action and various intrapsychic modes. Information is needed to answer the implicit or explicit questions inherent in appraisal. General knowledge permits a person to interpret events even if they have never been observed before. Specific knowledge is used to interpret and participate in events that people have experienced many times. If a person has a great deal of relevant specific knowledge, the inferential leap will be minimal and uncertainty should be quickly reduced. Inferences made on the basis of general correct knowledge should be

realistic and useful for primary and secondary appraisal (Anderson , 1977). Folkman, Schaefer & Lazarus (1979) stated that belief system was considered as a coping resource. Knowledge is related to belief system and is a kind of coping resources. When information is unclear or insufficient, it is more difficult to evaluate what the likely outcomes are and how they can best be dealt with. Folkman, et al. (1979) noted that instances of ambiguity and uncertainty, such as difficulties in interpersonal transactions, might be arisen from not knowing whether an event will occur, or its likely consequences. Proper knowledge base may therefore enhance effective coping and affect the belief systems subsequently. Therefore, the correct mental health knowledge acquired by the adolescent children of schizophrenic patients may effectively enhance their coping with the management problems caused by their mentally ill parents. Meanwhile, their beliefs and attitude toward mental patients and mental illness may be affected as well.

Knowledge is considered as an important coping resource in this study since knowledge/ information can be applied toward problem solving or reappraising the situation (Lazarus & Folkman, 1984), especially under the stressful family environment and specific stressors such as the management problems and social/economic costs exposed to the adolescent children of schizophrenic patients.

(a) ***Knowledge about schizophrenia***

In the present study of the adolescent children of schizophrenic parents, their knowledge about schizophrenia would be examined. Some studies have shown that the more the relatives possess the knowledge about schizophrenia, the more likely they reduce their criticism and hostility to the patient (Barrowclough, Tarrier, Watts, Vaughn, Bamrah & Freeman, 1987).

(b) ***Measurement about mental health knowledge***

In the West, some measuring tools had been developed to assess the mental health knowledge. Concerning the knowledge about schizophrenia, Barrowclough and his associates (1987) developed the *Knowledge about Schizophrenia Interview* (KASI). The KASI aims to assess the relative's information, beliefs and attitudes about six broad aspects of the illness: Diagnosis, Symptomatology, Aetiology, Medication, Prognosis, and Management. In the local context, Shek (1990) assessed secondary school students' mental health knowledge by the *Chinese Mental Health Knowledge Scale* (CMHKS). The test-retest reliability of this scale was examined and the reliability test showed that it was reliable (alpha=.71). In this study, the author constructed the ***Knowledge about Schizophrenia*** Scale to measure the

children's knowledge about the nature, etiology and treatment of schizophrenia and the available relevant services in Hong Kong.

3.8.4. *Attitude toward the ex-mental patients*

Many studies showed that the public still held a generally negative perspective toward the mentally ill (Farina, 1971; Green McCormick, Walkey & Taylor, 1987; Ramon, 1978). Trute, Tefft and Segall (1989) found no significant differences in the levels of public rejection of the mentally ill over a ten-year period. Socall and Holtgrave (1992) suggested that rejection of the mentally ill was associated with negative beliefs about them. In Hong Kong, there has been rarely study about the attitude of general public to the mentally ill. However, the strong and negative reaction of the residents of some neighbourhoods toward the establishment of half-way house and day centre cum social club reflected the prejudice and rejecting attitude toward the mentally ill.

(a) Mental health knowledge and attitude toward mental patients

Concerning the relationship of mental health knowledge with the attitude toward mental patients, McGill, Falloon, Boyd and Wood-Swerio (1983) also suggested that educating relatives, by giving them information about schizophrenia (composed of the components of knowledge, attitude and value), might lead to reduced criticism and hostility and a lowering of Expressed Emotions (EE). Vaughn and Leff

(1981) suggested that high-EE relatives tended to feel that patients could control their symptomatic behavior, and took a relatively unsympathetic view of the illness, whereas low-EE relatives believed that the patients suffered from a mental illness and could not control certain behavior.

Barrowclough, Tarrier, Watts, Vaughn, Bamrah & Freeman (1987) confirmed the positive correlation between education and attitude / acceptance toward the ex-mentally ill. Some research had reported that giving information about schizophrenia to relatives was part of larger psychosocial interventions that attempted to reduce relapse rates of patients suffering from schizophrenia (Goldstein & Kopeikin, 1981). Barrowclough and Tarrier (1984), in their study of families in coping with a family member suffering from schizophrenia, highlighted that the relatives who have acquired information were likely to have a beneficial influence on their interactions with the patients. They proposed that suggesting alternative explanations about the mental illness or the problems caused by mental patients might be the starting point of changing the relatives' beliefs and engaging them in a more positive approach to the management of patients' difficulties. In their study, education sessions were given to the relatives and a post-test following those sessions was administered to assess whether further attitude or belief was changed.

(b) Adolescents' attitude toward the mentally-ill

Adolescence is a critical stage in the development of attitudes toward politics, religion and morality. It may also be a discrete phase in the development of attitudes toward mental illness (Adelson, 1979). Therefore students may be the target group of studies concerning the attitude toward ex-mental patients (Reetz & Shemberg, 1978; Shek, 1988) . Norman and Malla (1983), in their study of 413 students with a modal age of 16 about their attitudes towards mental illness, noted that beliefs in psychosocial etiology and psychosocial treatment correlated positively with optimistic beliefs about prognosis. Belief in the appropriateness of psychosocial treatment was also related to greater social acceptance of the mentally ill, whereas belief in medical treatment was negatively related to social acceptance. In view of the findings of the above studies, mental health education in secondary schools should be enhanced to give students more extensive and accurate information based on a multi-modelled approach to mental illness. Then the adolescents' attitudes toward the rehabilitation and the acceptance of the mentally ill may be changed for more positive and favourable.

In the local context, Shek (1988) stated that many researchers had used the tripartite definition of attitude i.e. cognitive, affective and conative components (Rosenberg & Hovland, 1960). Shek (1990) also

speculated that obtaining information through mental health education contrary to one's beliefs would lead to attitude change. In Hong Kong, only a few studies had been conducted to explore the adolescent attitudes towards the mentally ill. Shek's (1988) study about the behavioral intentions of Chinese secondary school students toward ex-mental patients showed that students were generally not willing to have an ex-mental patient as their neighbor, to live under the same roof with him/her, or to marry him/her. Shek and Cheung (1990) also studied a sample of secondary school students about their mental health knowledge, their occupational trust in the ex-mentally ill as well as their attitudes toward the rehabilitation of ex-mental patients. The outcome of the research indicated that the respondents' trust in the competence of the ex-mentally ill to perform sophisticated jobs was minimal and they were afraid that the work incompetence of the ex-mental patients might cause detrimental effect to other people in the community. The above findings suggested that the ex-mental patients would encounter difficulties in their living environment, such as rejection and discrimination from their neighborhood and in occupational reintegration in the community. In addition, a significant proportion of the respondents had misconceptions of the nature of mental illness and mental health. This reflected the poor mental health knowledge among the students and the general public's misconception or ignorance to the mental illness which would hinder their acceptance to those with mental

illness. In view of the above, there is an immediate need to enhance the systematic mental health education in the formal curriculum for secondary school students, so that the myth, taboo and prejudice toward mental illness and mental patients may be removed step by step.

(c) ***Measurement of attitude toward mental illness and mental patients***

In the West, many scales had been developed to assess the public's attitude toward the mental illness and mental patients. For instances, 1) *The Opinions about Mental Illness Scales* (OMI) was developed by Cohen and Struening (1964) to measure attitudes toward mental illness, its etiology and treatment; 2) *Custodial Mental Illness Scale* (CMI) was developed by Gilbert and Levinson (1956) to measure beliefs about the mentally ill; (3) *Community Attitude toward Mentally Ill* (CAMI) Scale was developed by Dear and Taylor (1982) to focus on the community-based mental health care; (4) *Public Attitude to Ex-Mental Patients* developed by Askenasy (1974) mainly consisted of the occupational performance and trust, and willingness to relate to ex-mental patients in different context. This scale had been translated by Shek (1988) and administered to secondary school students. In this study, the author also adopted this scale to assess the respondents' attitude toward ex-mental patients.

3.9 Mental Health

Whilst the public are increasingly concerned with and aware of 'mental health', few can give it a clear definition or comprehend how it acts on our daily life. In common understanding, 'mental health' generally refers as the absence of mental illness. The clear picture of mental health lies on two components of 'mental' and 'health' which would be discussed on the following sections.

3.9.1 *Concept of "Mental"*

The term 'mental' refers to human functioning involving both the area of the brain and the nervous system. It results in intellectual functioning, emotional functioning or social functioning under the general heading 'mental functioning' (Heck, Gomez & Adams, 1973). Henceforth, 'mental' implies not solely on physiological state of cerebral activities, but also on one's emotional or affective state, his/her relationship with others, as well as on the general quality of equilibrium between his/her sociocultural context (Schwartz & Schwartz, 1968).

3.9.2 *Concept of "Health"*

Heck et al. (1973) purported two ways to conceptualize health: ideal concept and operational concept. The ideal concept, according to Heck, is a state of general well-being (Heck, Gomez & Adams, 1973).

And 'health', according to World Health Organization (1958), compasses senses of well-being, wholeness and soundness. In short , the 'ideal concept' refers to a state of positiveness within human being. The 'operational concept', on the other hand, refers to the absence of illness. Based on this concept, we frequently view people who are less vulnerable or absence from disease as 'healthy'.

3.9.3 *Mental Health as a Concept*

Evolving from the above concepts, many mental health professionals interpret that individuals who are sick "inside" and need treatment suffer from 'mental illness', just as physical illness (MacMurray, Cunningham, Carter, Swenson & Bellin, 1976). An active concept, in turn, maintains that the stressfulness of social condition may be associated with 'mental illness' (Binitie, 1984). Thus, 'mental health' may involve both the self and the social environment.

The concept of adjustment is important to the discussion of "mental health". Adjustment implies the establishment of workable arrangement between personal needs and social conditions. Active adjustment may be described as one's mastery of environment. One's mental health thus depended on the correct perception of reality. A well-adjusted individual develops a sense of self-worth, meaning a purpose in life and enjoyment or satisfaction with life. Peck and

Mitchell (1962) suggested that mental health should include the characteristics of objective judgment, rationality, autonomy, initiative, emotional maturity, self-regard, and respect for others.

Generally, the conception of mental health may be considered as the absence of psychological symptoms or having a positive sense. However, the definition of mental health in terms of the "absence of mental illness" criteria is too restrictive and it does not include those who are not diagnosed as having mental illness, but they are at the margin of having mental problems and need professional assistance. On the other hand, many psychologists tend to define mental health in terms of positive subjective experience with existential meaning. Maslow (1970) suggested that mental health included the characteristics of positive traits like efficient perception of reality, a high level of self-acceptance and tolerance to the reality and human nature, spontaneity, autonomy, close relationships with some others, creativeness, etc. Johoda (1956) proposed that the concept of active adjustment and mentally healthy was considered as having an integrated personality. Mental health might be defined as "positive perception of oneself", "self-actualization", "integration of personality, including a purpose and meaning in life" and "realistic perception of the environment". In fact the positive concept of mental health is prevalent in the recent years and

it may be defined as "happiness", "positive affect" and "life satisfaction" (Diener, 1984). Moreover, it may be defined in terms of "self-esteem" and "sense of self-worth" (Peck & Mitchell, 1962).

3.9.4 *Measurement of mental health*

The methods of measuring mental health include psychiatric interviews, guided interviews, symptoms reports, reports of physical status and ratings of social adjustments related to community, work, family and social interaction. Self-reports of symptoms are a sort of quantitative measure, whereas psychiatric interviews are a kind of qualitative way in data collection.

Regarding the measurement of morbidity, the self-report instruments including *General Health Questionnaire, Langner Scale, Beck Depression Inventory, Hopelessness Scale, State-trait Anxiety Inventory* and *Chinese Somatic Scale* are popular in Hong Kong. As for the measurement tools for positive mental health, the Chinese version of *Self-esteem Scale* and *Purpose in Life Questionnaire* have been shown to be reliable and internally consistent in the local context (BGCAHK, 1992; Leung, 1994; Wong, 1991).

Chapter Four

Literature Review on the Relationships Among Variables Under Study

Having examined the literature review on the major variables in Chapter 3, the relationships among variables (mainly the relationship between perceived stress and mental health, the relationship between perceived stress and coping resources, and the relationship between coping resources and mental health) would be presented in this chapter. Moreover, the research questions, hypotheses, conceptual framework and the definitions of variables would be briefly covered in the later part of this chapter.

4.1 Stress and mental health

Felner (1985), basing on the transactional-ecological perspectives, illustrated that children and youth who were faced with significant levels of hazardous environmental ***stress,*** as well as those who experienced difficulty in their transactions with others, were at increased risk for ***mental problems***. Compas, Davis, Forsythe & Wagner (1987) also found that ***chronic, daily hassles,*** such as those associated with poverty, as well as more stressful circumstances, had been strongly associated with ***mental***

disorders. Dubois, Felner, Brand, Adan, and Evans (1992) conducted a research on 166 adolescents and found that ***stresses*** made a significant contribution to ***psychological distress***.

Concerning the mental health of the caregivers of the mentally ill, Noh and Turner (1987) showed that level of ***stress*** experienced by caregivers was associated with the extent of ***psychological distress***. Webster (1992) stated that children who were exposed to ***conflict*** between parents or who became involved in a parent's delusional ideas were vulnerable to develop ***psychological difficulties*** (Rutter & Quinton, 1984). Lazarus and Folkman (1984) asserted that the ***perceived stress*** better predicted the ***psychological well-being*** than objective intensity of stressors. Cohen (1985) also indicated that personal meaning given to the ***stressors*** was more predictive of one's ***psychological well-being.***

Quine and Pahl (1986) studied the ***stress*** and coping of 166 mothers caring for a child with severe learning difficulties. They found that the mothers' ***ill-health*** was affected directly by poor ***assessment of coping abilities***. Noh and Turner (1987) stated the concept of ***subjective burdens*** which referred to the extent to which the patient's presence, behavior, and /or dependency was ***perceived*** as generating ***stress*** in the family. They further noted that the family members tended to pay a ***psychological price***

with respect to ***subjective burden*** for maintaining an mentally ill relative within the home.

From the above findings, it was observed that perceived stress was associated with mental health. A hypothesis might be set as:

"Lower perceived stress is associated with better mental health"

(Hypothesis 1)

4.2 Coping resources and perceived stress

4.2.1 *Self-efficacy and perceived stress*

Bandura had suggested that ***self-efficacy*** might operate as a cognitive mechanism through which feelings of controllability affected reaction to ***stress*** (Bandura & Adams, 1977). Bandura and his other colleagues further found that subjects with induced high perceived ***self-efficacy*** exhibited little ***stress***, whereas those with induced low perceived ***self-efficacy*** experienced a high level of ***stress*** (Bandura, Cioffi, Taylor, & Brouillard, 1988).

Much research had also depicted that increasing sense of ***self-efficacy*** or fostering positive beliefs about an individual's ability to successfully manage a stressful experience might help resisting ***stress*** (Cohen & Burt & Bjorck 1987; Holahan & Moos, 1981; Johnson &

Sarason, 1978; Lazarus & Folkman, 1984; Schiaffino & Revenson, 1992). Recently, Cozzarelli (1993) also found that feelings of ***self-efficacy*** were important adjustment behavior to ***negative life events***.

As the above findings showed that self-efficacy was associated with stress, a hypothesis might be set as follows:

"Higher social self-efficacy is associated with lower perceived stress"
(Hypothesis 2)

4.2.2 *Self-esteem and perceived stress*

Several studies had suggested a link between ***self-esteem*** and ***stress*** during adolescence (Cohen, Burt, & Bjorck, 1987). Youngs and associates (1990) examined over 2,100 teenage students and illustrated that the experience of ***negatively perceived events*** appeared to be the primary contributor to lowered ***self-esteem***.

From the above studies, it was shown that self-esteem was associated with stress / perceived stress, a hypothesis might be set as follows:

"Higher self-esteem is associated with lower perceived stress"
(Hypothesis 3)

4.2.3 *Knowledge and perceived stress*

Social knowledge is a kind of valuable ***knowledge*** through years of social observation and modeling (Argyle, 1982). Moreover, social knowledge may be used to manipulate other coping resources in the environment and it plays an important role in the process of ***stress*** resistance (Hobfoll, 1988). Concerning the knowledge about mental illness, Brown, Birley, & Wing (1972) suggested that a major contribution to high-EE (Expressed Emotion) was lack of ***knowledge about_schizophrenia*** by the relative. The correct knowledge might lead to ***reduced criticism and hostility*** and a ***lowering of EE.***

As shown in the above findings, knowledge was associated with stress/perceived stress and a hypothesis might be set as follows:

"More mental health knowledge is associated with lower perceived stress" (Hypothesis 4)

4.2.4 *Attitude and perceived stress*

Scheier and Carver (1985) suggested that optimistic***attitude*** had implications for the manner in which people deal with ***stresses*** of life (Lazarus, Kanner, & Folkman, 1980). Scheier, Weintraub and Carver

(1986) found that optimistic ***attitude*** motivated respondents to seek social support and emphasized the positive aspects of the ***stressful situation***. Moreover, they tended to adopt problem-focused coping strategy. On the other hand, pessimistic ***attitude*** was associated with denial and distancing, with focusing on ***stressful*** feelings. They tended to use emotion-focused coping strategy which was related to self-blame and self-isolation (Folkman & Lazarus, 1985). Scheier and Carver (1985) also illustrated that people with optimistic ***attitude*** do better than pessimists when confronted with ***stressful occurrences.***

From the above studies, attitude was found to be associated with perceived stress, and a hypothesis might be set as follows:

"More favourable attitude toward ex-mental patients is associated with lower perceived stress"

(Hypothesis 5)

4.3 Coping resources and mental health

4.3.1 *Self-efficacy and mental health*

Kahn and Long (1988) examined 56 female clerical workers and studied their work-related stress, ***self-efficacy*** and ***well-being*** . They found from the multiple regression that ***self-efficacy*** and perception of work ***stress*** significantly contributed to the explained variance of ***well-***

being (anxiety trait). Bandura and his colleagues also stated that ***perceived efficacy*** might reduce ***fear arousal*** (Bandura, Adams, Hardy, & Howell, 1980).

In a study of the ***self-efficacy*** formulation of ***depression***, Kanfer & Zeiss (1992) showed that depressed individuals perceived their self-efficacy as falling short of their personal standards of performance. In some studies of adolescents with depression, it was found that they had the sense of inadequacy in obtaining reinforcement, pleasure and satisfaction (Ehrenberg, Cox & Koopman, 1991). ***Self-efficacy***, therefore, provides a framework to examine the self-evaluative factors in adolescents' ***mental health*** , the perception of his / her ability to produce effective behaviour, as well as the internal standards of the individual. Connolly (1989) investigated 87 emotionally disturbed adolescents and found that ***social self-efficacy*** would vary with ***psychiatric status.*** The findings also supported ***social self-efficacy*** as a component of social competence and as a contributor to ***mental health.*** As reported, low ***self-efficacy*** was associated with ***anxiety and withdrawal.***

Ehrenberg, Cox and Koopman (1991) examined the self-efficacy status of 172 male and 194 female adolescents. They found that ***self-efficacy*** was negatively correlated with ***depression*** and concluded that

it had an important relationship with adolescent depression. As remarked in their study, academic self-efficacy and social self-efficacy were the most significant predictors of ***depression*** for early adolescent males. Moreover, failure in social relationships may bring about adolescent depression which is found significantly correlated with a general lack of ***self-efficacy*** (Ehrenberg, Cox & Koopman, 1991). Bandura (1986) also stated that the ***perceived inability*** to influence events and social conditions might give rise to ***feelings of futility and despondency.***

From the above studies, self-efficacy / social self-efficacy was found to be associated with mental health, and a hypothesis might be set as follows:

"Higher social self-efficacy is associated with better mental health" (Hypothesis 6)

4.3.2 *Self-esteem and mental health*

Greenberg, Pyszczynski, Burling, Solomon, Rosenblatt, Lyon and Pinel (1992) suggested that ***self-esteem*** was a central mechanism for protecting individuals from the ***anxiety***. Hobfoll (1988) also stated that ***self-esteem*** was related to lower ***depression***. Rosenberg, Schooler and Schoenbach (1989) studied ***self-esteem*** and adolescent problems by examining over 1,800 teenage boys. They found the causal relationship

between ***self-esteem*** and ***depression*** was bi-directional (Hulka, Cassel, Kupper,& Burdette, 1976).

From the above studies, self-esteem was found to be associated with mental health, and a hypothesis might be set as follows:

"Higher self-esteem is associated with better mental health"

(Hypothesis 7)

4.3.3 ***Knowledge and mental health***

Hobfoll (1988) stated that ***knowledge*** was a mobile resource that was carried with individuals wherever and whenever they went. According to Hobfoll , knowledge was also a vitally important energy resource which could facilitate the making of sound choices in ***coping with the stress*** in life's complex problems and consequently promote one's well-being.

As mental health knowledge was found to be associated with coping and well-being, a hypothesis might be set as follows:

"More correct mental health knowledge is associated with better mental health"

(Hypothesis 8)

4.3.4 *Attitude and mental health*

Attitude is a major factor of belief system which is crucial in appraisal and coping. Favourable attitude might be considered as a positive belief which is a very important psychological resource. Folkman, Schaefer, and Lazarus (1979) found that supportive beliefs as opposed to despair were implicated in positive social functioning and ***psychological well-being.***

The above finding showed that attitude was associated with mental health, and a hypothesis might be set as follows:

"More favorable attitude toward the ex-mental patients is associated with better mental health"

(Hypothesis 9)

4.4 Conceptual Framework

The research framework of this study was spelled out through the inter-relationships of major variables in **Figure 1**.

4.4.1 Perceived stress and mental health

From many studies, stress or perceived stress had been considered to have significant relationship with mental health (Lazarus & Folkman, 1984; Noh & Turner, 1987). In this study

of the mental health status of the adolescent children of schizophrenic patients, the author examined to see if the ***perceived stress*** (stemmed from the objective stressors caused by management problems, psychological problems and social / economic costs) would be strongly correlated with their ***mental health*** (in terms of psychiatric morbidity and hopelessness).

4.4.2 Coping resources and perceived stress

Other studies indicated that coping resources were correlated with stress / perceived stress (Lazarus, Kanner & Folkman, 1980). The adolescent children of schizophrenic patients may experience considerable stress in their family environment. However, the sense of social competence which they achieve in social interaction especially with their peers (***higher social self-efficacy***) may enhance their confidence and belief that they are capable of solving a problem or achieving some outcomes by their ability. This sense of accomplishment may reduce their ***perceived stress*** in handling and solving the problems arisen from their schizophrenic parents.

Self-esteem is another attribute which may strengthen their confidence in facing the ***stress*** especially when some schizophrenic parents tend to be aggressive, threatening and

undermining the self-worth of their children. The teenage children who have established ***high self-esteem*** may have ***higher resistance to stress*** and perceive the environment, self and future in a more positive way.

Those adolescent children who have ***favourable attitude toward ex-mental patients*** also reflect that they have more acceptance toward them including their "abnormal" behavior and thoughts. It is believed that those children of schizophrenic patients with more accepting attitude and tolerance toward mental patients should have better capacity to handle the ***stress*** caused by the objective problems.

Those adolescent children who have correct and proper ***mental health knowledge*** are considered to have less prejudice and bias toward mental patients. Moreover, they should have ***more capability and confidence*** to deal with the difficulties and adverse situation due to their mastery of skills of proper management of mental patients and the information about the available services. Based on the above discussion, it is worthwhile to examine whether all the four personal coping resources in this study help reduce the stress experienced by the adolescent children of schizophrenic patients.

4.4.3 Coping resources and mental health

Some studies also showed that coping resources were correlated with mental health (Hobfoll, 1988; Lazarus & Folkman, 1984). Positive beliefs are considered as a kind of coping resources which facilitate one to feel that outcomes are controllable and one has the ability to achieve the outcomes. ***Self-efficacy, self-esteem and attitude*** are related to belief systems of the individual and as mentioned before, are predictive of psychological well-being. The adolescent children of the schizophrenic patients are at a critical developmental stage to build up their self-concept, and belief / value system. It is thus suitable to examine their personal coping resources which are crucial to their growth and development. Knowledge is a kind of utilitarian resources. Lacking correct ***mental health knowledge*** implies that they may have insufficient understanding of the nature of the mental illness and would have more anxieties toward the unpredictability of the relapse of their mentally ill parents. Moreover, lacking knowledge also implies that they have insufficient skills and methods to manage the problems caused by the patients, and it in turn may cause more frustrations and worries in the teenage children.

This study is not aimed at testing any theoretical models, but simply to examine the four personal coping resources, and their relationships with perceived stress and mental health. Based on the above discussion concerning the relationships among major variables in different studies, the research questions of this study would be raised in the following section.

4.5 Research Questions and Hypotheses

1. What ***stressors*** are faced by the adolescent children of schizophrenic parents?

   How often do ***stressors*** related to i) ***management problems*** caused by their parents' maladaptive behaviour; ii) their own ***psychological problems***; and iii) the ***social and economic costs*** appear?

2. Do the adolescent children of schizophrenic parents have ***perceived stress*** and what type of perceived stress they experience when they encounter stressors related to the management of their parents' problems, their psychological problems and social and economic costs?

3. Do children of schizophrenic parents display any problems regarding ***social self-efficacy***?

4. Do children of schizophrenic parents have any problem regarding ***self-esteem*** ?

5. What ***mental health knowledge*** do the adolescent children of schizophrenic parents have?

6. What is the ***attitude*** of the adolescent children of schizophrenic parents toward ex-mental patients?

7. What is the ***mental health*** status of the adolescent children with schizophrenic parents?

8. How do the adolescent children of schizophrenic patients perceive the services provided by medical social workers?

9. What are the services considered by the adolescent children of the schizophrenic parents as most needed by their schizophrenic parents?

10. What are the services most needed by the adolescent children of schizophrenic parents?

11. What is the relationship between ***perceived stress*** and ***psychological well-being***?

    (Hypothesis 1: Lower perceived stress is associated with better mental health) --- Section 4.1

12. What is the relationship between ***coping resources*** and ***perceived stress***?

    a. What is the relationship between ***social self-efficacy*** and ***perceived stress***?

       (Hypothesis 2: Higher social self-efficacy is associated with lower perceived stress) --- Section 4.2.1

    b. What is the relationship between ***self-esteem*** and ***perceived stress***?

       (Hypothesis 3: Higher self-esteem is associated with lower perceived stress) --- Section 4.2.2

    c. What is the relationship between ***mental health knowledge*** and ***perceived stress*** ?

       (Hypothesis 4: More correct mental health knowledge is associated with lower perceived stress) --- Section 4.2.3

d. What is the relationship between ***attitude toward ex-mental patients*** and ***perceived stress*** ?

(Hypothesis 5: More favorable attitude toward the mental patients is associated with lower perceived stress) — Section 4.2.4

13. What is the relationship between ***coping resources*** and ***psychological well-being*** ?

a. What is the relationship between ***social self-efficacy*** and ***psychological well-being*** ?

(Hypothesis 6: higher social self-efficacy is associated with better mental health) --- Section 4.3.1

b. What is the relationship between ***self-esteem*** and ***psychological well-being*** ?

(Hypothesis 7: higher self-esteem is associated with better mental health) --- Section 4.3.2

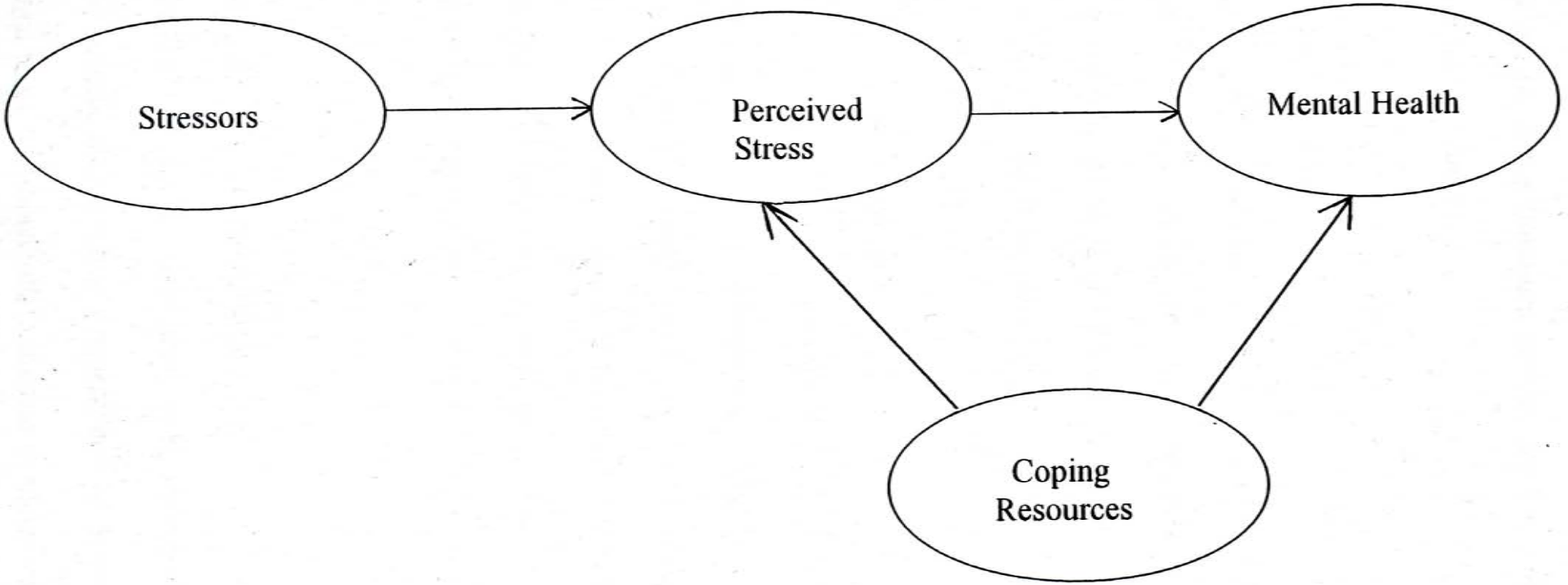
c. What is the relationship between ***mental health knowledge*** and ***mental health*** ?

(Hypothesis 8: more correct mental health knowledge is associated with better mental health) --- Section 4.3.3

d. What is the relationship between ***attitude toward mental patients*** and ***mental health*** ?

(Hypothesis 9: more favorable attitude toward the mental patients is associated with better mental health) --- Section 4.3.4

Figure 1 The Conceptual Model of Stressors, Perceived Stress, Coping Resources and Mental Health



1. Social Self-efficacy
2. Self-esteem
3. Knowledge
4. Attitude

4.6 Definition of concepts

Based on the above literature review, the key concepts of this study were defined as follows:

4.6.1 *Definition of stressors*

Stressors refers to the long-term social, economic and psychological problems faced by the adolescent children of schizophrenic patients, as well as the management problems arising from living with a schizophrenic parent.

4.6.2 *Definition of perceived stress*

Perceived stress refers to a perception of stress arising from the objective stressors which are management problems, psychological problems, social and economic costs. In the transaction with the environment, the adolescent children of schizophrenic patients appraised stressors by degree of stressfulness and the strength of the resources they may employ and the availability of resources to fit the stress-related demands.

4.6.3 *Definition of social self-efficacy*

Social self-efficacy is considered as a coping resource in this study and it reflects an individual's expectation of personal mastery of specific social tasks that contribute to success in social relationships.

4.6.4 *Definition of self-esteem*

Self-esteem is an evaluation which the individual makes and maintains with regard to himself; it expresses an attitude of approval or disapproval, and indicates the extent to which the individual believes himself to be capable, successful, significant and worthy. Individual with high self-esteem respects himself, considers himself worthy while low self-esteem implies self-rejection, self-dissatisfaction, and self-contempt.

4.6.5 *Definition of knowledge about schizophrenia*

Knowledge about schizophrenia includes the nature, etiology, symptomatology, treatment, prognosis of schizophrenia, and the services available for them in Hong Kong.

4.6.6 *Definition of behavioral intentions / attitude*

Behavioral intentions refers to the person's stated intention to perform a particular behavior with respect to the object of consideration. The term attitude is used interchangeably with behavioral intentions which can be used to represent the affective, cognitive and conative components of attitudes. In this study, behavioral intentions / attitude are referred to that of the adolescent children of schizophrenic parents toward the ex-mental patients.

4.6.7 *Definition of mental health*

In this study, mental health refers as the absence of mental health problems which may be narrowed down to anxiety, depression, inadequate coping, interpersonal dysfunctioning, and sleep disturbance; moreover, mental health also refers to a sense of hope (low level of hopelessness may be narrowed down to hopelessness, uncertainty about the future and future expectation).

Chapter Five

Research Methodology

5.1 *Sample Design*

This study utilized a one-time and cross-sectional social survey design which was conducted through face-to-face interviews with structured and closed-ended questionnaire. It was a non-probability and non-random sampling which depended on the convenient availability of the respondents. Actually all the research subjects were selected and recommended by the medical social workers of respective psychiatric clinics or hospitals. Eight-eight subjects were taken from adolescent children aged from 12 to 19 whose schizophrenic parents were receiving out-patient / in-patient treatment and medical social service. The following psychiatric units/clinics/centres/hospitals of the Hospital Authority were chosen as the sampling units (sampling frame) for the research. They were Kowloon Hospital Psychiatric Unit (25), Yau Ma Tei Psychiatric Centre (17), Pamela Youde Nethersole Eastern Hospital Psychiatric Out-Patient Clinic (4), Violet Peel Psychiatric Centre (1), East Kowloon Psychiatric Clinic (4), South Kwai Chung Psychiatric Centre (7) and Tuen Mun Polyclinic (8), Kwai Chung Hospital (13) and Castle Peak Hospital (9). Consent from each patient and respondent (or from respondent's parent if the respondent was under 18) was obtained for every case involved in the research. Fifty-six interviews were

conducted by the author while thirty-two interviews were conducted by 3 research assistants (2 of them were social work trained) who had received adequate guidance from the author. Most of the interviews were conducted at the clients' home and a small gift was presented to each respondent after the interview.

5.2 Instruments for Measurement

The questionnaire consisted of the following scales:
(For details, please refer to English version of the Questionnaire.)

5.2.1 *Scale measuring the stressors (ST-ALL) and Perceived Stress (PS-ALL)*

This measuring instrument was self-constructed. Based on the study of Noh and Turner (1987), Hatfield (1978), Atkinson (1986) and Wong (1991), the scale included the construct of objective stressors and perceived stress of the children related to the demand of and interaction with the schizophrenic parents. These stressors may be classified into 3 sub-scales: i) management problems, ii) psychological problems, iii) social/economic costs. This scale was a four-point scale indicating the frequency of occurrence of stressors and the intensity of perceived stress which might be classified as management problems, psychological problems, social and economic costs faced by the adolescent children.

5.2.2 *Rosenberg Self-esteem Scale (RSES)*

The scale was devised by Rosenberg (1965) to measure attitudes towards self. It is a 10-item Likert-type scale with each item having five

possible responses indicating strength of agreement with the items. The higher the numerical score, the higher the self-reported level of self-esteem. Therefore, a score of 40 represented the highest level of self-esteem an individual could have, whereas a 10 represented the lowest level. Acceptable levels of test-retest and internal consistency reliability and convergent, discriminate, and construct validity have been found for the RSES (Rosenberg, 1979). The Chinese version of the scale was translated by Shek (1992) with acceptable reliability.

5.2.3 *Adolescent Social Self-efficacy Scale (SEFF)*

This scale consisted of 25 items denoting the description of common social events considered to be problematic for adolescents (Ford, 1982; Furnham & Argyle, 1975). These problems could be grouped into (i) social assertiveness, (ii) performance in public situations, (iii) participation in social groups, (iv) friendship and intimacy, and (v) giving and receiving help. It is measured by a seven-point Likert Scale ranging from "impossible to do" to "extremely easy to do". The total score was calculated by adding up individual ratings given to each of the items. The scale was translated into Chinese by the author, with emphasis on the consistent and comprehensive meaning of the translated version.

5.2.4 *Knowledge about Schizophrenia Scale (SKS)*

Based on the Chinese Mental Health Knowledge Scale (CMHKS), the descriptions of the problems and symptoms in the studies of Barrowclough & Tarrier (1984) and Creer and Wing (1974), the author constructed this scale which consisted of 35 true-false items to measure the teenagers' knowledge about schizophrenia. For the true-false items, the subjects could respond 'Yes', 'No' or 'Not Sure' to the items. The first fifteen questions (Area 1) emphasized the understanding of the behavior/emotions of the patients. Questions 16 -- 25 (Area 2) focus on the knowledge about the nature of schizophrenia, its aetiology and treatment course of patients. Questions 26-35 (Area 3) were about the available services for mental patients in Hong Kong. The items were constructed on the basis of face validity and consensus was achieved among mental health professionals (psychiatrists, psychiatric nurses, warden of half-way house and medical social workers) to ensure that the items included reflected the concept of schizophrenia.

5.2.5 *Behavioral Intention toward Ex-mental Patients Scale (BIEMP)*

The cognitive dimension of public's attitude toward mental illness and ex-mental patients was measured by this scale (Askenasy, 1974). The Chinese version of the scale (C-BIEMP), which was found to have satisfactory reliability (Cronbach's alpha=.78 and Guttman's split-half reliability coefficient=.73) (Shek, 1988), was employed. The original scale has 6 items which were 1) work with an ex-mental patient;

2) work under an ex-mental patient; 3) to hire an ex-mental patient; 4) to invite a ex-mental patient to home; 5) to have an ex-mental patient as neighbor; and 6) to have an ex-mental patient in the same household. The Chinese version included item 7 which asks whether the respondent is willing to get married with an ex-mental patient.

5.2.6 *General Health Questionnaire (GHQ-30)*

This scale was a self-report questionnaire designed by Goldberg (1972) measuring current psychiatric (non-psychotic) disturbances in general practice settings. Items asked whether the respondent has recently experienced a particular symptom or behavioral response as described by the item. The responses could range from "Much less than usual", "Less than usual", "Same as usual" to "More than usual". The Chinese version of the GHQ-60 was translated by Chan (1985) and its reliability and validity measures were established. The scale was also modified to GHQ-30 which excluded physical illness items and balanced positive and negative items. The Chinese version of GHQ-30 was translated by Chan & Chan (1983) and its reliability and validity were established (Shek, 1987). It assessed five dimensions of psychiatric morbidity, including anxiety, inadequate coping, depression, sleep problems and social dysfunctioning areas. Total GHQ responses might be scored by the Likert (0-1--2-3) and GHQ (0-0-1-1) scoring methods.

5.2.7 *Chinese version of Hopelessness Scale (C-Hope)*

This scale was devised by Beck, Weissman, Lester, Trexler (1974) who showed that it had high internal consistency. It consisted of 20 true-false items to quantify the degree of pessimism in an individual. The Chinese version of the Hopelessness Scale (C-Hope) has locally established internal consistency and acceptable reliability status (Shek, 1993).

5.2.8 *Demographic / personal data*

The final part of the questionnaire was the family background and socio-economic information. Such information included age, sex, educational background of the respondents and their parents, living condition, family income and its source, marital status of parents, etc. And also, the respondents would be asked about their opinions about the social service provided by the social worker, and the services / assistance they considered their mentally-ill parents and they themselves needed most.

(Please refer to Appendix A for the English Version of the Questionnaire).

Chapter Six

Results

The data and findings would be presented in this chapter. Section 6.1 would cover the psychometric properties of the instruments employed in this study. Section 6.2 would describe the general demographic characteristics of the respondents. Section 6.3 would report the social services perceived by the respondents as most needed by their parents and themselves. Section 6.4 would present the descriptive findings concerning the aspects of stress, coping resources and mental health of the respondents. Finally, the correlations among variables with respect to the various hypotheses would be illustrated in Section 6.5.

6.1 Psychometric properties of the measuring instruments

6.1.1 *Measurement of stress*

(a) *Stressor Scale (ST-ALL)*

This self-constructed scale consisted 45 items which are grouped into three categories of problems. They are i) the management problem (ST-MP), ii) the psychological problem (ST-PP), and iii) the social and economic costs (ST-SEC). The reliability and item-total correlations for the items in the scales are presented in Table 1. The results showed that

the whole scale (ST-ALL) was reliable and internally consistent (Cronbach's alpha = 0.9365). Most of the items had item-total correlations in excess of 0.3 except items 5, 6, 15, 23, 31, 41 and 45. The item-total correlations of the sub-scales of ST-MP was 0.9214, ST-PP was 0.7825 and ST-SEC was 0.7206. Their reliability was satisfactory, indicating that they were internally consistent (Tables 2, 3, 4).

(b) ***Perceived Stress Scale (PS-ALL)***

The item-total correlations and overall reliability of the whole scale (PS-ALL) were presented in Table 5. This scale was found to be reliable (Cronbach's alpha = 0.9483). Most of the individual items in the scale had high item-total correlations in excess of 0.3 except items 15, 21, 23, 26 and 31. The sub-scales of PS-MP, PS-PP and PS-SEC were found to be internally consistent and the values of Cronbach's alpha were 0.9312, 0.8456 and 0.7538 respectively (Tables 6, 7, 8) which indicating that they had high internal consistency.

6.1.2 *Measurement of coping resources*

(a) ***Adolescent Social Self-efficacy Scale (SEFF)***

The whole scale (SEFF) was found to be reliable and internally consistent as most of the items had item-total correlations in excess of

0.4 except items 1, 5, 8, 12, 15, 16, 17, 19 and 23. The Cronbach's alpha was 0.8783 (Table 9).

(b) ***Rosenberg Self-esteem Scale (RSES)***

The item-total correlations and the overall reliability were presented in Table 10. The results showed that the scale was moderately reliable and internally consistent as the Cronbach's alpha was 0.6459. Item 8 was found to be negatively correlated with other items.

(c) ***Knowledge about Schizophrenia Scale (SKS)***

The item-total correlations and overall reliability for the scale were shown in Table 11. This scale was found to be fairly reliable and consistent. The Cronbach's alpha was 0.6830. Items 6, 18 and 34 were negatively correlated with other items.

(d) ***Behavioral intention toward Ex-mental Patients Scale (BIEMPS)***

The item-total correlations and overall reliability were presented in Table 12. It was found that Cronbach's alpha, being 0.7560, was acceptable. Over half of the items had item-total correlations in excess of 0.3 except items 6 and 7. This scale was therefore an internally consistent and a reliable instrument.

6.1.3 *Measurement of mental health*

(a) *General health questionnaire - 30 (GHQ-30)*

Table 13 showed the item-total correlations and the reliability of the GHQ-30 (Likert's Scoring). The Cronbach's alpha was 0.9160 and most individual items indicated high item-total correlations which were in excess of 0.3 except items 4, 5, 9, 11, 13 and 18.

For GHQ-30 (0-0-1-1 Scoring), the Cronbach's alpha was 0.9043 and most individual items had high item-total correlations except items 3, 4, 13 and 18 which were below the value of 0.3. (Table 14)

(b) *Chinese-Hopelessness Scale (C-Hope)*

The item-total correlations and overall reliability were shown in Table 15. The Cronbach's alpha of the scale was 0.9007 which suggested that it was a reliable and internally consistent instrument. Most individual items showed high item-total correlations except item 3.

(The reliability and values of Item-Total Correlation of the above scales are presented in the following tables (Table 1 to Table 15) from page 116 to page 132.)

Table 1

Reliability and Item-Total Correlation of Stressor Scale (ST-ALL)

I T E M	ITEM - TOTAL CORRELATION
1. Throwing temper without reason	.5284
2. Emotionally being disturbed	.3948
3. Isolated and withdrawn	.4620
4. Inappropriate expression of feelings	.5463
5. No facial expression	.2578
6. Emotionally down / depressed	.2803
7. Bizarre thought (Being controlled or persecuted)	.7192
8. Having hallucination obviously	.6569
9. Suspicious	.5577
10. Sleeping disturbance	.4891
11. Self-muttering	.7090
12. Poor personal hygiene	.4299
13. Having ill feeling or hatred towards another	.6011
14. Bizarre belief	.6045
15. Having suicidal thought	.2283
16. Having self-destructive behavior	.4638
17. Having disturbing behavior at home	.5805
18. Having relapse at home	.7003
19. Refuse medication	.5889
20. Refuse follow-up treatment	.5867
21. Become glassy at home	.3681
22. Waste money	.6433
23. Over smoking	.2981
24. Causing disturbance due to excessive drinking	.4503
25. Lack of insight	.3202
26. Poor concentration	.3504
27. Lack of working motivation	.3258
28. Passive	.4943
29. Show no response to others	.4351

Table 1 (continued) Reliability and Item-Total Correlation of Stressor Scale (ST-ALL)

I T E M	ITEM - TOTAL CORRELATION
30. Unwilling to do the housework	.7625
31. Anxious when meeting psychiatric rehabilitation professionals	.1110
32. Upset by having to take care of your parent	.5057
33. Embarrassed to attending social event with your parent	.5725
34. Ashamed of telling people about your parent	.5163
35. Guilty for not able to spot the sight of relapse of your parent	.4298
36. Feel sad that you cannot communicate clearly with your parent	.4670
37. Annoyed that you have to take care of the your parent	.4275
38. Confused of having to face the unusual behaviors of your parent	.6375
39. Have to take up more housework.	.5933
40. Visit hospitalized parent	.3300
41. Financial problem in the family.	.2699
42. Your daily living is affected.	.7167
43. Disagreement among family members.	.4285
44. Your social life is affected.	.4490
45. Complaints from neighbors.	.2591
A L P H A	.9365

Table 2

Reliability and Item-Total Correlation of Subscale of Stressor Scale – Management Problem (ST - MP)

I T E M	ITEM - TOTAL CORRELATION
1	.5822
2	.3844
3	.4576
4	.5744
5	.3215
6	.2975
7	.7381
8	.6391
9	.5268
10	.5277
11	.6926
12	.5228
13	.6173
14	.4089
15	.2756
16	.4970
17	.6762
18	.6952
19	.5947
20	.4906
21	.3339
22	.6740
23	.2404
24	.4979
25	.3075
26	.3249
27	.3784
28	.5727
29	.4322
30	.7206
A L P H A	.9214

Table 3

Subscale of Stressor Scale – Psychological Problem (ST - PP)

I T E M	ITEM - TOTAL CORRELATION
31	.1023
32	.5206
33	.6048
34	.6345
35	.5037
36	.5306
37	.4603
38	.5330
A L P H. A	.7825

Table 4

Subscale of Stressors Scale – Social / Economic Costs (ST - SEC)

I T E M	ITEM - TOTAL CORRELATION
39	.6771
40	.4323
41	.3710
42	.7528
43	.2200
44	.4321
45	.1760
A L P H A	.7206

Table 5

Perceived Stress Scale (PS-ALL)

I T E M	ITEM - TOTAL CORRELATION
1	.6014
2	.6954
3	.4175
4	.6808
5	.3271
6	.3337
7	.7422
8	.6826
9	.5783
10	.6998
11	.7921
12	.4656
13	.5937
14	.5369
15	.2964
16	.4332
17	.7565
18	.6966
19	.6146
20	.5094
21	.2844
22	.5593
23	.2879
24	.5840
25	.4271
26	.1817
27	.3072
28	.5513
29	.5802
30	.6581
31	.2782
32	.4560
33	.5795

Table 5 (continued) **Perceived Stress Scale (PS-ALL)**

I T E M	ITEM - TOTAL CORRELATION
34	.4797
35	.5172
36	.5928
37	.6581
38	.6853
39	.7973
40	.4308
41	.3422
42	.7231
43	.4323
44	.3864
45	.3181
A L P H A	.9483

Table 6

Subscale of Perceived Stress Scale -- Management Problem (PS - MP)

I T E M	ITEM - TOTAL CORRELATION
1	.6223
2	.4868
3	.4029
4	.6869
5	.3572
6	.2792
7	.7500
8	.6675
9	.5338
10	.7282
11	.7706
12	.5014
13	.6253
14	.5291
15	.3347
16	.4717
17	.7550
18	.7703
19	.6074
20	.4707
21	.2857
22	-.6065
23	.2821
24	.6278
25	.4459
26	.1298
27	.3736
28	.5762
29	.5412
30	.6445
A L P H A	.9312

Table 7

Reliability and Item-Total Correlation of Perceived Stress - Psychological Problems (PS - PP)

I T E M	ITEM - TOTAL CORRELATION
31	.3588
32	.6309
33	.6899
34	.6660
35	.4917
36	.5648
37	.5671
38	.6670
A L P H A	.8456

Table 8

Reliability and Item-Total Correlation of Perceived Stress – Social / Economic Costs (PS - SEC)

I T E M	ITEM - TOTAL CORRELATION
39	.6068
40	.5115
41	.3580
42	.6836
43	.4920
44	.4853
45	.1651
A L P H A	.7538

Table 9

Reliability and Item-Total Correlation of Social Self-Efficacy Scale (SEFF)

I T E M	ITEM - TOTAL CORRELATION
1. Start a conversation with a boy or girl who you don't know very well	.3524
2. Express your opinion to a group of kids discussing a subject which is of interest to you	.4740
3. Join a group of kids in the school cafeteria for lunch	.4674
4. Work on a project with student you don't know very well	.5281
5. Help make a new student feel comfortable with your group of friends	.3136
6. Share with a group of kids an interesting experience you once had	.4452
7. Put yourself in a new and different social situation	.4605
8. Volunteer to help organize a school dance	.3328
9. Ask a group of kids who are planning to go to a movie if you can join them	.6023
10. Stand up for your rights when someone accuse you of doing something you have not done	.4059
11. Get invited to a party that's being given by one of the most popular kids in the class	.4048
12. Keep up your side of the conversation	.3779
13. Be involved in group activities	.6152
14. Find someone to spend recess with.	.6021
15. Wear the kind of clothes you like even if they are different from what others wear	.2821
16. In a line-up, tell a student who pushes in front of you to wait for his or her turn	.3494
17. Stand up for yourself when another kid in your class makes fun of you	.3684
18. Help a student who is visiting your school for a short time to have fun and interesting experiences	.5515
19. Join a school club or sports team	.3536
20. Express your feelings to another kid	.5979
21. Ask someone come to your house on a Saturday	.4296

Table 9 (continued) Reliability and Item-Total Correlation of Social Self-Efficacy Scale (SEFF)

I T E M	ITEM - TOTAL CORRELATION
22. Ask someone to go for a school dance or movie with you	.5461
23. Go to a party where you are sure you won't know any of the kids	.3242
24. Ask another student for help when you need it	.5941
25. Make friends with kids of your age	.4120
A L P H A	.8783

Table 10

Reliability and Item-Total Correlation of Rosenberg Self-Esteem Scale (RSES)

I T E M	ITEM-TOTAL CORRELATION
1. On the whole I am satisfied with myself	.2744
2. At times I think I am no good at all	.3778
3. I feel that I have a number of good qualities	.3018
4. I am able to do things as well as most other people.	.2324
5. I feel I do not have much to be proud of	.3510
6. I certainly feel useless at times	.4149
7. I feel that I am a person of worth	.2055
8. I wish I could have more respect for myself	-.0200
9. All in all, I am inclined to think that I am a failure	.5800
10. I take a positive attitude toward myself	.3642
A L P H A	.6459

Table 11

Reliability and Item-Total Correlation of Knowledge about Schizophrenia Scale (SKS)

I T E M	ITEM-TOTAL CORRELATION
1. Schizophrenia means personality splitting	.1909
2. The intelligence level of a schizophrenic patient is poorer than a normal person	.0839
3. Generally speaking, most schizophrenic patients has a greater tendency of hurting him / herself	.1507
4. The short-term memory of most schizophrenic patients has been damaged	.1526
5. Generally speaking, most schizophrenic patients are more aggressive	.2384
6. Most schizophrenic patients easily get worried	-.0373
7. Most schizophrenic patients have suicidal tendency	.3186
8. Most schizophrenic patients are having autism at the same time	.3008
9. Most schizophrenics are poor in budgetting	.0130
10. Most schizophrenics are usually lazy at work	.1865
11. Schizophrenic patients often deliberate absurd behaviors	.4495
12. Most schizophrenic patients are lacking of determination	.2556
13. Most schizophrenic patients are stubborn	.3591
14. Generally speaking, schizophrenic patients are poor in impulse control	.2058
15. Most schizophrenics are socially withdrawn	.1155
16. It is more easily for the lower class /grassroots people to suffer from schizophrenia	.3068
17. The chance of having schizophrenia is nearly the same between two sexes	.0940

Table 11 (continued) **Reliability and Item-Total Correlation of Knowledge about Schizophrenia Scale (SKS)**

I T E M	ITEM-TOTAL CORRELATION
18. If your parents or siblings are schizophrenics, you have a higher chance of becoming one	-.0944
19. If the state of mind of a schizophrenic patient is more stable, he/she can voluntarily take less medicine	.1252
20. Lower socio-economic status is one of the main causes for the relapse of schizophrenia	.3414
21. Experiencing stressful life events is one of the causes of schizophrenia	.0130
22. "Largactil" and "Haloperidol" are the two commonly used medicine for schizophrenia	.1114
23. Taking medicine over a long period of time is the only way to treat schizophrenia	.1865
24. Losing appetite is one of the side-effects of anti-psychotic drugs	.2375
25. Generally speaking, the possibility of relapse will be reduced with age	.1524
26. Schizophrenic patients may seek medical consultation from the concerned clinic / hospital before the date of appointment if needed	.1108
27. The regional hospitals managed by the Hong Kong Hospital Authority all provide bedspaces for psychiatric patients	.3008
28. One may call the hot-line service of the SWD if a mental patient relapses	.2667
29. Most of the residents living in the half-way house are male	.2885
30. The Mental Health Association of Hong Kong has already started the "telephone inquiry service for mental health"	.2354
31. The service provided by the day hospital has to be arranged by social workers	.1698

Table 11 (continued) **Reliability and Item-Total Correlation of Knowledge about Schizophrenia Scale (SKS)**

I T E M	ITEM-TOTAL CORRELATION
32. Labor Department has set up the Selective Placement Service to seek jobs for ex-mental patients with doctor's referral	.3955
33. Ex-mental patients who have limited working capacity can attend the day training centre or sheltered workshop	.2911
34. All schizophrenic patients are eligible to apply for Disability Allowance	-.1705
35. "Resources Centre" for the family members of the mental patients has not yet been commenced	.2795
A L P H A	.6830

Table 12

Reliability and Item-Total Correlation of Behavioral Intentions Toward Ex-Mental Patient Scale (BIEMPS)

I T E M	ITEM - TOTAL CORRELATION
1. Work with an ex-mental patient	.7365
2. Work under an ex-mental patient	.3002
3. Hire an ex-mental patient	.6283
4. Invite an ex-mental patient to home	.7181
5. Have an ex-mental patient as your neighbor	.6279
6. Have an ex-mental patient in the same household	.1102
7. Marry an ex-mental patient	.2986
A L P H A	.7560

Table 13

Reliability and Item-Total Correlation of General Health Questionnaire GHQ-30 (Likert Scoring)

ITEM	ITEM - TOTAL CORRELATION
1. Not able to concentrate on whatever you're doing	.4091
2. lost much sleep over worries	.5900
3. having restless, disturbed nights	.4790
4. managing to keep yourself busy and occupied	.0775
5. not getting out of the house as much as usual	.2746
6. not managing as well as most people would in your shoes	.3481
7. not feeling on the whole you were doing things well	.4499
8. not satisfied with the way you're carried out your task	.3511
9. not able to feel warmth and affection for those near to you	.2783
10. finding it not easy to get on with other people	.4886
11. spent much time chatting with people	.1293
12. felt that you are not playing a useful part in things	.4664
13. felt incapable of making decisions about things	.0458
14. felt constantly under strain	.5925
15. felt that you couldn't overcome your difficulties	.5074
16. finding life a struggle all the time	.6227
17. not able to enjoy your normal day-to-day activities	.6238
18. not taking things hard	.2539
19. getting scared or panicky for no good reason	.6429
20. not able to face up to your problems	.3276
21. found everything getting on top of you	.5221
22. feeling unhappy and depressed	.6698

Table 13 (continued) **Reliability and Item-Total Correlation of General Health Questionnaire GHQ-30 (Likert Scoring)**

ITEM	ITEM - TOTAL CORRELATION
23. losing confidence in yourself	.7486
24. thinking of yourself as a worthless person	.7535
25. felt that life is entirely hopeless	.6632
26. not feeling hopeful about your own future	.6743
27. not feeling reasonably happy in all things considered	.7071
28. feeling nervous and strung-up all the time	.7511
29. felt that life isn't worth living	.6454
30. found at times you couldn't do anything because you are too nervous	.6030
ALPHA	.9160

Table 14

Reliability and Item-Total Correlation of General Health Questionnaire GHQ - 30 (0-0-1-1)

ITEM	ITEM - TOTAL CORRELATION
1	.3976
2	.4599
3	.2486
4	.2175
5	.3564
6	.4276
7	.6371
8	.4614
9	.3088
10	.5259
11	.3606
12	.5947
13	.2403
14	.4838
15	.5328
16	.5561
17	.5658
18	.2822
19	.6120
20	.3844
21	.4517
22	.5585
23	.6297
24	.5583
25	.4888
26	.6047
27	.6066
28	.6702
29	.4996
30	.4862
ALPHA	.9043

Table 15

Reliability and Item-Total Correlation of Chinese Version of Hopelessness Scale (C - Hope)

I T E M	ITEM - TOTAL CORRELATION
1. I look forward to the future with hope and enthusiasm.	.6754
2. I might as well give up because I can't make things better for myself	.7485
3. When things are going bad, I am helped by knowing they can't stay that way forever	.0937
4. I can't imagine what my life would be like in 10 years	.4995
5. I have enough time to accomplish the things I mostly want to do	.4002
6. In the future, I expect to succeed in what concerns me most	.3585
7. My future seems dark to me	.7791
8. I expect to get more of the good things in life than the average person	.3845
9. I just don't get the breaks, and there's no reason to believe I will in the future	.7147
10. My past experiences have prepared me well for my future	.5309
11. All I can see ahead of me is unpleasantness rather than pleasantness	.6158
12. I don't expect to get what I really want	.5501
13. When I look ahead to the future, I expect I will be happier than I am now	.3955
14. Things just won't work out the way I want them to be	.4864
15. I have great faith in the future	.5984
16. I never get what I want so it's foolish to want anything	.5897
17. It is very unlikely that I will get any real satisfaction in the future	.6649
18. The future seems vague and uncertain to me	.6280
19. I can look forward to more good times than bad times	.3985
20. There's no use in really trying to get something I want because I probably won't get it	.5989
A L P H A	.9007

6.2 Demographic characteristics of the respondents

This section attempts to present a brief socio-demographic profile of the respondents. A total of 88 respondents participated in this study. The following frequency distributions were shown in Table 16.

6.2.1 *Sex and age of respondents*

Among the respondents, 42 (47.7%) were males and 46 (52.3%) were females. The age of the respondents ranged from 12 to 19 and the mean age was 15.14. Thirty-seven respondents fell into the age group of 12 to 14 (42%), 37 in the age group of 15 to 17 (42%) and 14 were at the age of 18 or above (16%).

6.2.2 *Relationship of respondents to their schizophrenic parents*

All the male respondents were biological sons and all the females were biological daughters of their schizophrenic parents.

6.2.3 *Education level of respondents*

As illustrated, 24 (27.3%) of respondents were studying in primary school, 61 (69.3%) was studying in secondary school, and 3 (3.4%) had tertiary level.

6.2.4 *Number of siblings of the respondents and their rank among siblings*

It was indicated that 30 respondents (22.8%) had 1 to 3 siblings, 51 (69.3%) had 4 or more siblings, and 7 (7.9%) had no siblings. As presented in the table, 32 respondents (36.4%) were ranked the first among the siblings, 56 (63.6%) ranked the second or below.

6.2.5 *Religion of respondents*

It was shown that 37 (42%) of the respondents had no religion, 36 (40.9%) were Protestants, 5 (5.7%) were Catholics, 10 (11.4%) believed in Buddhism.

6.2.6 *Out-patient or in-patient status of respondents' schizophrenic parents*

From the table, it was found that 57 respondents' (64.8%) schizophrenic parents were attending out-patient clinics while 31 (35.2%) of respondents' schizophrenic parents were hospitalized. Among the in-patients, the duration of their hospitalization ranged from 5 days to 3 months.

6.2.7 *Education level of the parents*

As indicated, 21 respondents' (23.9%) fathers were illiterate, 43 (48.9%) had reached primary education, 21 (23.8%) had reached secondary education and 3 (3.4%) had reached tertiary level; 12 respondents' (13.6%) mothers were illiterate, 55 (62.5%) had primary education and 21 (23.9%) had secondary school level. The figures showed that 72.8% / 76.1% of the respondents' fathers / mothers were illiterate / poorly educated.

6.2.8 *Occupation of the respondents' parents, the family's income and its source*

As illustrated, 61 respondents' (69.3%) schizophrenic parents were employed and 27 (30.7%) unemployed. Among those employed, 48 (54.5%) were manual workers. As for the financial condition, it was reported that 29 (33%) of the respondents' total family income was below $5,000 per month, 49 (55.7%) were between $5,001 and $10,000, 10 (11.3%) were over $10,000.

As for the principal sources of income of the respondents' families, 27 respondents' families (30.7%) were depending on Comprehensive Social Security Assistance (CSSA); 47 (53.4%) from

fathers; 7 (8.0%) from mothers; 3 (3.4%) from siblings, 4 (4.5%) from other resources which includes rentals or on savings.

6.2.9 *Type of accommodation and family size within the same household*

61 respondents (69.3%) were living in public housing estates, 11 (12.5%) in rented rooms, 4 (4.5%) in rented flats, and 7 (8.0%) in self-owned premises, and 5 (5.7%) in other housing arrangements.

No respondent had a family size of only 2 persons , 36 (40.9%) had 3 to 4 persons , and 52 (59.1%) had 5 or more persons in a family.

6.2.10 *Marital status of respondents' parents*

It was found that 72 (81.8%) respondents' parents were legally married, 2 (2.3%) not married, 11 (12.5%) separated, 3 (3.4%) divorced. Among these parents, 11 (12.5%) were widow/widower.

6.2.11 *Principal caregivers of the respondents' schizophrenic parents*

As reported, 52 (59.2%) respondents' parents were the principal caregivers of the schizophrenic patient at home; 15 (17.0%) respondents were from siblings; 4 (4.5%) respondents' relatives were the principal caregivers, and 17 (19.3%) respondents themselves were the principal caregivers.

Table 16

Basic Demographic Characteristics of the Respondents (N=88)

Demographic Characteristics	N	%
Sex		
Male	42	47.7
Female	46	52.3
Age		
12 - 14	37	42
15 - 17	37	42
18 or above	14	16
Education Level		
Primary School	24	27.3
Secondary School	61	69.3
Tertiary Level	3	3.4
No. of Siblings		
0	7	7.9
1 - 3	30	22.8
4 or above	51	69.3
Respondent's Rank		
Eldest	32	36.4
Younger	56	63.6
Religion		
Protestant	36	40.9
Catholic	5	5.7
Buddhism	10	11.4
No Religion	37	42.0
Status		
Out-patient	57	64.8
Hospitalized	31	35.2

Table 16 (continued) Basic Demographic Characteristics of the Respondents (N=88)

Demographic Characteristics	N	%
Father's Education		
Illiterate	21	23.9
Primary School	43	48.9
Secondary School	21	23.8
Tertiary Level	3	3.4
Mother's Education		
Illiterate	12	13.6
Primary School	55	62.5
Secondary School	21	23.9
Tertiary Level	0	0
Employment		
Employed	61	69.3
Manual Work	*48*	*54.5*
Others	*13*	*14.8*
Unemployed	27	30.7
Income ($)		
Below 5,000	29	33.0
5,001 - 10,000	49	55.7
Over 10,000	10	11.3
Income Source		
CSSA	27	30.7
From father	47	53.4
From mother	7	8.0
From Siblings	3	3.4
Others	4	4.5

Table 16 (continued) Basic Demographic Characteristics of the Respondents (N=88)

Demographic Characteristics	N	%
Housing		
Public housing estate	61	69.3
Rented room	11	12.5
Rented flat	4	4.5
Self-owned premise	7	8.0
Others	5	5.7
Marital Status		
Married	72	81.8
Not married	2	2.3
Separated	11	12.5
Divorced	3	3.4
Widowed / Non-widowed		
Widowed	11	12.5
Non-widowed	77	87.5
Household Size		
Only 2	0	0
3 - 4	36	40.9
5 or over	52	59.1
Principal Caregivers		
Parents	52	59.2
Siblings	15	17.0
Relatives	4	4.5
Respondents	17	19.3
TOTAL Respondents	88	100

6.3 Respondents' perception of the existing services and expressed needs

As illustrated in Table 17, the respondents' perception of the existing services were reported as follows:

6.3.1 *Number of respondents who had visited social workers in the past 6 months and their satisfaction rates with the service of social workers*

11 respondents (12.5%) had visited and 77 (87.5%) had not visited social workers with their schizophrenic parents in the last 6 months (Table 17a).

Concerning the satisfaction rates of the respondents with the service of social workers, 11 respondents (12.5%) indicated that the service of social worker was ineffective; 70 (79.5%), effective; and 7 (8.0%), very effective (Table 17b).

6.3.2 *The social services which were considered by the respondents as important for their schizophrenic parents*

As illustrated, respondents considered that their schizophrenic parents needed the following services:

First priority (Table 17c) :

1. Psychological assistance (48.9%)
2. Financial assistance (30.7%)
3. Mental health education (13.6%)

4. Others (6.8%)

Second priority (Table 17d):

1. Mental health education (36.4%)
2. Psychological assistance (21.6%)
3. Financial assistance (19.3%)
4. Others (22.7%)

6.3.3 *The social services which were needed by respondents*

Respondents reported to have a need for the following social services:

First priority (Table 17e):

1. Education on management of psychiatric problems (34.1%)
2. Training on stress management (29.5%)
3. Interpersonal skills training (21.6%)
4. Counselling service (10.2%)

Second priority (Table 17f):

1. Training on stress management (38.6%)
2. Counseling service (22.7%)
3. Interpersonal skills training (18.2%)
4. Education on management of psychiatric problems (14.8%)
5. Others (5.7%)

Table 17

Respondents' Perception of the Existing Services and Expressed Needs

Table 17a

Number of Respondents Who Had Seen Social Workers in the Past 6 Months

Yes/No	N	%
Yes	11	12.5
No	77	87.5
Total	88	100

Table 17b

Number of Respondents Who Considered the Service of Social Worker as Effective

Effectiveness	N	%
Very Effective	7	8.0
Effective	70	79.5
Non-Effective	11	12.5
Total	88	100

Table 17c

First Priority Services Needed by Schizophrenic Parents (reported by respondents)

First Priority Services	N	%
Psychological assistance/ Counselling	43	48.9
Financial Assistance	27	30.7
Mental Health Education	12	13.6
Others	6	6.8
Total	88	100

Table 17 (Continued) **Respondents' Perception of the Existing Services and Expressed Needs**

Table 17d

Second Priority Social Services Needed by Schizophrenic Parents

Second Priority Services	N	%
Mental Health Education	32	36.4
Psychological assistance/ Counselling	19	21.6
Financial Assistance	17	19.3
Others	20	22.7
Total	88	100

Table 17e

First Priority Social Services Needed by Respondents

First Priority Services	N	%
Education on Management of Psychiatric Problems	30	34.1
Training on Stress Management	26	29.5
Interpersonal Skills Training	19	21.6
Counselling service	9	10.2
Others	4	4.6
Total	88	100

Table 17 (Continued) Respondents' Perception of the Existing Services and Expressed Needs

Table 17f

Second Priority Social Services Needed by Respondents

Second Priority Services	N	%
Training on Stress Management	34	38.6
Counselling service	20	22.7
Interpersonal Skills Training	16	18.2
Education on Management of Psychiatric Problems	13	14.8
Others	5	5.7
Total	88	100

6.4 Findings of stress, coping and mental health of respondents

6.4.1 Stress

(a) *Stressors faced by respondents*

Stressors Scale (ST-ALL) used 45 items to measure the stressors faced by respondents. Respondents who rated "Occasionally" or "Always" were classified as those who frequently faced the stressors (See Table 18).

Over 35% of the respondents either "Occasionally" or "Always" encountered the following management problems. These problems are listed in descending order of relative frequencies as follows:

having sleeping disturbance (item 10, 73.8%)
being emotionally disturbed (item 2, 72.8%)
throwing temper tantrums without reason (item 1, 55.7%)
being glassy at home (item 21, 53.5%)
having relapse of mental illness at home (item 18, 51.1%)
being emotionally depressed (item 6, 50%)
having bizarre thought (item 7, 50%)
being unwilling to do the housework (item 30, 47.7%)
being self-muttering (item 11, 38.7%)
being suspicious (item 9, 38.6%)
having hallucination obviously (item 8, 38.6%)
being lack of working motivation (item 27, 38.6%)

Concerning the psychological problems, the respondents most frequently faced the stressor of item 36, which was "feeling sad for failing to communicate clearly with schizophrenic parent" (43.2%), and this was followed by item 34, which was "feeling ashamed of telling people about his/her schizophrenic parent" (40.9%), then item 33, "feeling ashamed to attending social events with his/her schizophrenic parent" (34.1%).

Concerning the social and economic costs, it was found that the most frequently reported items by respondents were item 39, "having to take up more housework" (60.2%); then it was followed by stressors of item 42, "daily living is affected" (51.1%); item 40, "visit hospitalized

parent" (48.9%); item 41, "financial problem in family" (43.2%); and item 43, "disagreement among family members" (45.4%), then item 44, "social life is affected" (27.3%).

Although this study could not be completely compared with Wong's (1991) study about caregivers, a list of some of Wong's findings might serve as a reference. Actually, from the findings in this study, it was found that almost 20% of the respondents were principal caregivers of their schizophrenic parents. From Wong's (1991) findings, the items with the highest response rate in the Chronic Strain Scale were "Refuse to perform household duties" (63.5%), "bizarre behaviors" (50.7%) and "spend a great deal of time in bed" (40.6%). When compared with the findings in this study, "bizarre behavior" had similar percentage of responses, but the adolescent children seemed to be more concerned and felt stressful about patient's emotional disturbance, temper tantrums, rather than the residual symptoms.

(b) ***Perceived stress experienced by respondents***

Perceived Stress Scale (PS-ALL) used 45 items to measure the perception of stress experienced by respondents. Respondents who rated "Considerable" or "Very Great" were classified as those who frequently experienced the stress (See Table 19).

Over 25% of the respondents either "Occasionally" or "Always" encountered the following problems. These problem are listed in descending order of relative frequencies as follows:

having relapse at home (item 18, 45.5%)
being emotionally disturbed (item 2, 37.5%)
throwing temper tantrums without reason (item 1, 36.3%)
having bizarre thought (item 7, 34.1%)
having ill feeling or hatred toward another person(item 13, 31.8%)
having disturbing behavior at home (item 17, 31.8%)
being unwilling to do the housework (item 30, 31.8%)
having sleeping disturbance (item 10, 29.6%)
being suspicious (item 9, 27.3%)
having suicidal thought (item 15, 27.3%)
being self-muttering (item 11, 26.1%)
being inappropriate expression of feelings (item 4, 26.1%).

Concerning the psychological problems of the respondents, over 20% of the respondents experienced stress caused by item 38 (confused of having to face the unusual behaviors of the parent, 29.6%), then followed by item 36 (feeling sad for failing to communicate clearly with the parent, 28.4%), and then by item 33 (embarrassed to attending social events with the parent, 23.8%).

Concerning the social and economic costs, it was found that 42% of the respondents experienced stress stemmed from "financial problem

in family" (item 41), then followed by stress related to "disagreement among family members" (item 43, 37.5%), and "daily living is affected" (item 42, 34.1%), and then "having to take up more housework" (item 39, 26.1%).

From Wong's (1991) study, the items of Itemized Perceived Stress Scale which had highest response rate were "Fluctuation of emotions" (33.8%), "Bizarre behaviors" (24.3%), and "Not taking drugs on scheduled time" (23%). When compared with the findings in this study, it seemed that higher percentage of respondents (adolescent children) felt stressful toward the objective stressors.

6.4.2 Coping resources

(a) *Distribution of responses to the items in Social Self-efficacy Scale (SEFF)*

As shown in Table 20, some items were being rated toward the "uneasy tasks" dimension (rated in either "slightly possible to do", "moderately impossible to do" or "impossible to do"), which indicated real difficulty in social self-efficacy. Over 30% of the respondents displayed difficulty with respect to the following items:

1. go to a party where you are sure you won't know any of the kids (item 23, 70.4%)

2. start a conversation with a boy or girl who you don't know very well (item 1, 45.4%)

3. ask someone over to your house on a Saturday (item 21, 40.9%)

4. stand up for yourself when another kid in your class makes fun of you (item 17, 35.2%)

5. help a student who is visiting your school for a short time to have fun and interesting experiences (item 18, 31.9%)

(b) ***Distribution of responses to the items in the Rosenberg Self-Esteem Scale (RSES)***

As shown in Table 21, a significant proportion of respondents (over 30%) rated in the *negative direction* . They are listed as follows:

Item 8: I wish I could have more respect for myself (88.7%)

Item 2: At times I think I am no good at all (52.2%)

Item 5: I feel I do not have much to be proud of (43.2%)

Item 6: I certainly feel useless at times (43.2%)

Item 1: On the whole, I am satisfied with myself (39.8%)

Item 4: I am able to do things as well as most of other people" (30.7%)

(c) ***Distribution of responses to the items in the knowledge about Schizophrenia Scale (SKS)***

As illustrated in Table 22, the percentage data on the respondents' responses to the various items in the SKS showed that the mean percentage of "Not Sure" about the answers to the items was

42.4%. It was found that the average of percentage scores of the correct answers obtained by the respondents was 32.0%, ranged from 1.1% to 76.1%. The mean percentage of "incorrect" response to the items was 25.6%.

The items which showed the highest scores of correct answers are listed as follows:

Item 21: Experiencing stressful life events is one of the causes of schizophrenia (76.1%)

Item 33: Ex-mental patients who have limited working capacity can attend the day training centre or sheltered workshop (65.9%)

Item 26: Schizophrenic patients may seek medical consultation from the concerned clinic / hospital before the date of appointment if needed (60.2%)

Item 23: Taking medicine over a long period of time is the only way of treatment (58.0%)

The items with the highest proportion that the respondents gave the incorrect answers are listed as follows:

Item 6 : Schizophrenic patients easily get worried (69.3%)

Item 5 : Schizophrenic patients are more aggressive (56.8%)

Item 14: Schizophrenic patients are poor in impulse control (61.4%)

Item 18 : If your parents or siblings are schizophrenics, you have a higher chance of becoming one (58%)

Item 11 : Schizophrenic patients often deliberate absurd behaviors (54.5%)

The items with the highest proportion that the respondents gave the "Not sure" response are listed as follows:

Item 22: "Largactil" and "Haloperidol" are the two commonly used medicine for schizophrenia (94.4%)

Item 35: "Resources Centre" for the family members mental patients had not yet been commenced (79.6%)

Item 29: Most of the residents living in the half-way house are male (62.5%)

Item 31: The service provided by day hospital had to be arranged by social workers (59.1%)

Item 8: Most schizophrenics are having autism at the same time (55.6%)

(d) ***Distribution of responses to the items in the Behavioral Intention toward Ex-mental Patient Scale (BIEMP)***

From Table 23, a significant proportion of the respondents indicated that they would be willing to interact with an ex-mental patient in the following specific context (over 70%):

i) have an ex-mental patient as neighbor (80.7%).

ii) invite an ex-mental patient to home (72.7%),

iii) work with an ex-mental patient (71.6%),

iv) hire an ex-mental patient (70.5%).

Table 23 also showed that a significant proportion of the respondents indicated that they would not be willing to interact with an ex-mental patient in the following specific context:

i) marry an ex-mental patient (80.7%),

ii) have an ex-mental patient in the same household (63.6%),

iii) work under an ex-mental patient (45.5%).

6.4.3 Mental health

(a) *Distribution of responses to the items in the General Health Questionnaire 30 (GHQ-30)*

From Table 24, the items on which a significant proportion of respondents answered in a higher pathological direction (rated "same as / not more than usual" or "much more than usual") are listed as follows:

Item 14:	Felt under strain (39.8%)
Item 21:	Felt everything on top (39.8%)
Item 6:	Not managing well (38.6%)
Item 16:	Found life a struggle (35.2%)
Item 11:	Not chatting with others (34.1%)
Item 28:	Nervous and strung up (33.0%)
Item 5:	Not out of house (31.8%)
Item 30:	Too nervous (31.8%)

According to the 0-0-1-1 scoring method and using 5/6 as the cut-off point, Table 25 indicated that 45 respondents (52.9%) were classified as "case", and 43 respondents (47.1%) were considered as "non-cases". Such percentage indicated that almost half of the respondents could be classified as "at risk". The prevalence ratio of the

present study was higher than that of the caregivers, which was found to be 31.1% by Wong (1991). It indicated that adolescent children might face greater chance of experiencing mental health problems.

(b) ***Distribution of responses to the items in the Chinese Version of Hopelessness Scale (C-Hope)***

As shown in Table 26, the most prevailing reported items (negative direction) were listed as follows (the percentage was the sum of the 3 scores -- "Totally agree", "Moderately agree" and "Slightly agree") :

1. Things not work out the way I want (item 14, 64.8%)
2. Can't imagine what my life would be in 10 years (item 4, 55.6%)
3. Future seems vague and uncertain (item 18, 50.0%)

(The distributions of responses to the items in the above scales are presented in the following tables (Table 18 to Table 26) from page154 to page165.)

Table 18

Frequency Distribution of Responses to the Items in the Stressor Scale (ST-ALL)

Sub-scale 1 Management Problems (Items 1 - 30)

Item	Never	Rarely	Occasionally	Always
1. Throwing temper without reason	4 (4.5%)	35 (39.8%)	31 (35.2%)	18 (20.5%)
2. Emotionally being disturbed	3 (3.4%)	21 (23.8%)	54 (61.4%)	10 (11.4%)
3. Isolated and withdrawn	38 (43.2%)	30 (34.1%)	16 (18.2%)	4 (4.5%)
4. Inappropriate expression of feelings	21 (23.9%)	30 (34.1%)	25 (28.4%)	12 (13.6%)
5. No facial expression	26 (29.5%)	33 (37.5%)	22 (25.0%)	7 (8.0%)
6. Emotionally down / depressed	10 (11.4%)	34 (38.6%)	36 (40.9%)	8 (9.1%)
7. Bizarre thought (Being controlled or persecuted)	28 (31.8%)	16 (18.2%)	27 (30.7%)	17 (19.3%)
8. Having hallucination obviously	31 (35.2%)	23 (26.2%)	22 (25.0%)	12 (13.6%)
9. Suspicious	16 (18.2%)	38 (43.2%)	22 (25.0%)	12 (13.6%)
10. Sleeping disturbance	11 (12.5%)	12 (13.7%)	42 (47.7%)	23 (26.1%)
11. Self-muttering	26 (29.5%)	28 (31.8%)	18 (20.5%)	16 (18.2%)
12. Poor personal hygiene	40 (45.5%)	26 (29.5%)	13 (14.8%)	9 (10.2%)
13. Having ill feeling or hatred towards another	32 (36.4%)	28 (31.8%)	17 (19.3%)	11 (12.5%)
14. Bizarre belief	34 (38.6%)	29 (33.0%)	14 (15.9%)	11 (12.5%)
15. Having suicidal thought	43 (48.9%)	34 (38.6%)	8 (9.1%)	3 (3.4%)
16. Having self-destructive behavior	55 (62.5%)	25 (28.5%)	4 (4.5%)	4 (4.5%)
17. Having disturbing behavior at home	19 (21.6%)	35 (39.8%)	25 (28.4%)	9 (10.2%)
18. Having relapse at home	23 (26.1%)	20 (22.8%)	28 (31.8%)	17 (19.3%)
19. Refuse medication	32 (36.3%)	19 (21.7%)	17 (19.3%)	20 (22.7%)
20. Refuse follow-up treatment	51 (58.0%)	21 (23.8%)	11 (12.5%)	5 (5.7%)
21. Become glassy at home	18 (20.5%)	23 (26.0%)	29 (33.0%)	18 (20.5%)
22. Waste money	38 (43.2%)	21 (23.8%)	11 (12.5%)	18 (20.5%)
23. Over smoking	71 (80.7%)	11 (12.5%)	2 (2.3%)	4 (4.5%)
24. Causing disturbance due to excessive drinking	74 (84.1%)	11 (12.5%)	3 (3.4%)	0 (0%)
25. Lack of insight	31 (35.2%)	36 (40.9%)	21 (23.9%)	0 (0.0%)
26. Poor concentration	18 (20.5%)	37 (42.0%)	27 (30.7%)	6 (6.8%)

Table 18 (continued) Frequency Distribution of Responses to the Items in the Stressors Scale (ST-ALL)

Subscale 2 ***Psychological problems (Item 31-38)***
Subscale 3 ***Social/economic costs (Item 39 - 45)***

Item	Never	Rarely	Occasionally	Always
27. Lack of working motivation	23 (26.1%)	31 (35.3%)	25 (28.4%)	9 (10.2%)
28. Passive	29 (33.0%)	33 (37.5%)	15 (17.0%)	11 (12.5%)
29. Show no response to others	28 (31.8%)	30 (34.1%)	23 (26.1%)	7 (8.0%)
30. Unwilling to do the housework	28 (31.8%)	18 (20.5%)	14 (15.9%)	28 (31.8%)
31. Anxious when meeting psychiatric rehabilitation professionals	37 (42.0%)	27 (30.8%)	23 (26.1%)	1 (1.1%)
32. Upset by having to take care of your parent	38 (43.2%)	28 (31.8%)	18 (20.5%)	4 (4.5%)
33. Embarrassed to attending social events with your parent	34 (38.6%)	24 (27.3%)	21 (23.9%)	9 (10.2%)
34. Ashamed of telling people about your parent	24 (27.3%)	28 (31.8%)	28 (31.8%)	8 (9.1%)
35. Guilty for not able to spot the sight of relapse of your parent	45 (51.1%)	26 (29.6%)	15 (17.0%)	2 (2.3%)
36. Feel sad that you cannot communicate clearly with your parent	25 (28.4%)	25 (28.4%)	28 (31.8%)	10 (11.4%)
37. Annoyed that you have to take care of your parent	35 (39.8%)	32(36.3%)	18 (20.5%)	3 (3.4%)
38. Confused of having to face the unusual behaviors of your parent	24 (27.3%)	37 (42.0%)	19 (21.6%)	8 (9.1%)
39. Have to take up more housework.	14 (15.9%)	21 (23.9%)	37 (42.0%)	16 (18.2%)
40. Visit hospitalized parent	19 (21.6%)	26 (29.5%)	29 (33.0%)	14 (15.9%)
41. Financial problem in the family	15 (17.0%)	35 (39.8%)	21 (23.9%)	17 (19.3%)
42. Your daily living is affected	15 (17.0%)	28 (31.9%)	34 (38.6%)	11 (12.5%)
43. Disagreement among family members	18 (20.5%)	30 (34.1%)	25 (28.4%)	15 (17.0%)
44. Your social life is affected	37 (42.0%)	27 (30.7%)	18 (20.5%)	6 (6.8%)
45. Complaints from neighbors	59 (67.0%)	26 (29.6%)	2 (2.3%)	1 (1.1%)

Table 19

Frequency Distribution of Responses to the Items in the Perceived Stress Scale (PS-ALL)

Subscale 1. Management Problems (Items 1-30)

Item	Never	Little	Considerable	Very Great
1. Throwing temper without reason	9 (10.2%)	47 (53.5%)	23 (26.1%)	9 (10.2%)
2. Emotionally being disturbed	5 (5.7%)	40 (56.8%)	30 (34.1%)	3 (3.4%)
3. Isolated and withdrawn	53 (60.2%)	28 (31.9%)	3 (3.4%)	4 (4.5%)
4. Inappropriate expression of feelings	37 (42%)	28 (31.9%)	17 (19.3%)	6 (6.8%)
5. No facial expression	48 (54.5%)	34 (38.7%)	4 (4.5%)	2 (2.3%)
6. Emotionally down / depressed	18 (20.5%)	56 (63.6%)	10 (11.4%)	4 (4.5%)
7. Bizarre thought (Being controlled or persecuted)	30 (34.1%)	28 (31.8%)	20 (22.7%)	10 (11.4%)
8. Having hallucination obviously	41 (46.6%)	31 (35.2%)	13 (14.8%)	3 (3.4%)
9. Suspicious	21 (23.9%)	43 (48.8%)	16 (18.2%)	8 (9.1%)
10. Sleeping disturbance	21 (23.9%)	41 (46.5%)	13 (14.8%)	13 (14.8%)
11. Self-muttering	34 (38.6%)	31 (35.3%)	12 (13.6%)	11 (12.5%)
12. Poor personal hygiene	44 (50.0%)	30 (34.0%)	7 (8.0%)	7 (8.0%)
13. Having ill feeling or hatred towards another	35 (39.8%)	25 (28.4%)	19 (21.6%)	9 (10.2%)
14. Bizarre belief	40 (45.5%)	30 (34.0%)	13 (14.8%)	5 (5.7%)
15. Having suicidal thought	47 (53.4%)	17 (19.3%)	18 (20.5%)	6 (6.8%)
16. Having self-destructive behavior	58 (65.9%)	14 (15.9%)	10 (11.4%)	6 (6.8%)
17. Having disturbing behavior at home	25 (28.4%)	35 (39.8%)	20 (22.7%)	8 (9.1%)
18. Having relapse at home	26 (29.5%)	22 (25.1%)	22 (25.0%)	18 (20.5%)
19. Refuse medication	40 (45.5%)	29 (32.9%)	9 (10.2%)	10 (11.4%)
20. Refuse follow-up treatment	55 (62.5%)	28 (31.8%)	2 (2.3%)	3 (3.4%)
21. Become glassy at home	33 (37.5%)	42 (47.7%)	6 (6.8%)	7 (8.0%)
22. Waste money	48 (54.5%)	20 (22.8%)	9 (10.2%)	11 (12.5%)
23. Over smoking	75 (85.2%)	8 (9.1%)	0 (0.0%)	5 (5.7%)
24. Causing disturbance due to excessive drinking	75 (85.2%)	7 (8.0%)	5 (5.7%)	1 (1.1%)
25. Lack of insight	53 (60.2%)	29 (33.0%)	5 (5.7%)	1 (1.1%)

Table 19 (continued) Frequency Distribution of Responses to the Items in the Perceived Stress Scale (PS-ALL)

Subscale 2. Psychological Problems (Items 31-38)
Subscale 3. Social/economic costs (Items 38-45)

Item	Never	Little	Considerable	Very Great
26. Poor concentration	37 (42%)	42 (47.8%)	9 (10.2%)	0 (0.0%)
27. Lack of working motivation	36 (40.9%)	35 (39.7%)	10 (11.4%)	7 (8.0%)
28. Passive	47 (53.4%)	24 (27.3%)	9 (10.2%)	8 (9.1%)
29. Show no response to others	28 (31.8%)	42 (47.7%)	10 (11.4%)	8 (9.1%)
30. Unwilling to do the housework	39 (44.3%)	21 (23.9%)	14 (15.9%)	14 (15.9%)
31. Anxious when meeting psychiatric rehabilitation professionals	46 (52.3%)	32 (36.3%)	7 (8.0%)	3 (3.4%)
32. Upset by having to take care of your parent	43 (48.9%)	24 (27.2%)	16 (18.2%)	5 (5.7%)
33. Embarrassed to attending social events with your parent	41 (46.6%)	26 (29.6%)	12 (13.6%)	9 (10.2%)
34. Ashamed of telling people about your parent	31 (35.2%)	35 (39.8%)	13 (14.8%)	9 (10.2%)
35. Guilty for not able to spot the sight of relapse of your parent	43 (48.9%)	33 (37.5%)	8 (9.1%)	4 (4.5%)
36. Feel sad that you cannot communicate clearly with your parent	32 (36.4%)	31 (35.2%)	15 (17.0%)	10 (11.4%)
37. Annoyed that you have to take care your parent	41 (46.6%)	34 (38.6%)	10 (11.4%)	3 (3.4%)
38. Confused of having to face the unusual behaviors of your parent	31 (35.2%)	31 (35.2%)	21 (23.9%)	5 (5.7%)
39. Have to take up more housework.	29 (33.0%)	36 (40.9%)	14 (15.9%)	9 (10.2%)
40. Visit your hospitalized parent	29 (33.0%)	44 (50.0%)	14 (15.9%)	1 (1.1%)
41. Financial problem in the family.	24 (27.3%)	27 (30.7%)	23 (26.1%)	14 (15.9%)
42. Your daily living is affected.	17 (19.3%)	41 (46.6%)	16 (18.2%)	14 (15.9%)
43. Disagreement among family members	23 (26.1%)	32 (36.4%)	18 (20.5%)	15 (17.0%)
44. Your social life is affected.	45 (51.1%)	24 (27.3%)	12 (13.6%)	7 (8.0%)
45. Complaints from neighbors	64 (72.7%)	22 (25.0%)	0 (0.0%)	2 (2.3%)

Table 20

Frequency Distribution of Responses to the Items in the Social Self-efficacy Scale (SEFF)

Item	Impossible to do	Moderately impossible to do	Slightly possible to do	Occasionally possible to do	Slightly easy to do	Moderately easy to do	Extremely easy to do
1. Start a conversation with a boy or girl who you don't know very well	3 (3.4%)	6 (6.8%)	31 (35.2%)	17 (19.4%)	19 (21.6%)	11 (12.5%)	1 (1.1%)
2. Express your opinion to a group of kids discussing a subject which is of interest to you	0 (0.0%)	1 (1.1%)	8 (9.1%)	11 (12.5%)	19 (21.6%)	28 (31.8%)	21 (23.9%)
3. Join a group of kids in the school cafeteria for lunch	4 (4.5%)	2 (2.3%)	3 (3.4%)	6 (6.8%)	2 (2.3%)	10 (11.4%)	61 (69.3%)
4. Work on a project with a student you don't know very well	1 (1.1%)	8 (9.1%)	11 (12.5%)	18 (20.5%)	27 (30.7%)	12 (13.6%)	11 (12.5%)
5. Help make a new student feel comfortable with your group of friends	0 (0.0%)	5 (5.7%)	11 (12.5%)	16 (18.1%)	22 (25.0%)	21 (23.9%)	13 (14.8%)
6. Share with a group of kids an interesting experience you once had	5 (5.7%)	4 (4.5%)	12 (13.6%)	9 (10.3%)	9 (10.2%)	22 (25.0%)	27 (30.7%)
7. Put yourself in a new and different social situation	4 (4.5%)	4 (4.5%)	11 (12.5%)	32 (36.4%)	19 (21.6%)	10 (11.4%)	8 (9.1%)
8. Volunteer to help organize a school dance	4 (4.5%)	5 (5.7%)	24 (27.3%)	16 (18.2%)	12 (13.6%)	9 (10.2%)	18 (20.5%)
9. Ask a group of kids who are planning to go to a movie if you can join them	5 (5.7%)	5 (5.7%)	7 (8.0%)	21 (23.7%)	24 (27.3%)	10 (11.4%)	16 (18.2%)
10. Stand up for your rights when someone accuse you of doing something you have not done	5 (5.7%)	0 (0.0%)	6 (6.8%)	20 (22.7%)	27 (30.7%)	20 (22.7%)	10 (11.4%)
11. Get invited to a party that's being given by one of the most popular kids in the class	1 (1.1%)	2 (2.3%)	9 (10.2%)	26 (29.6%)	12 (13.6%)	16 (18.2%)	22 (25.0%)
12. Keep up your side of the conversation	3 (3.4%)	6 (6.8%)	3 (3.4%)	17 (19.4%)	15 (17.0%)	23 (26.1%)	21 (23.9%)

Table 20 (continued) Frequency Distribution of Responses to the Items in the Social Self-efficacy Scale (SEFF)

Item	Impossible to do	Moderately impossible to do	Slightly possible to do	Occasionally possible to do	Slightly easy to do	Moderately easy to do	Extremely easy to do
13. Be involved in group activities	0 (0.0%)	3 (3.4%)	5 (5.7%)	13 (14.8%)	23 (26.1%)	24 (27.3%)	20 (22.7%)
14. Find someone to spend recess with	3 (3.4%)	3 (3.4%)	6 (6.8%)	13 (14.8%)	18 (20.5%)	20 (22.7%)	25 (28.4%)
15. Wear the kind of clothes you like even if they are different from what others wear	3 (3.4%)	11 (12.5%)	8 (9.1%)	26 (29.5%)	13 (14.8%)	14 (15.9%)	13 (14.8%)
16. In a line-up, tell a student who pushes in front of you to wait for his or her turn	7 (8.0%)	2 (2.3%)	14 (15.9%)	22 (24.9%)	13 (14.8%)	21 (23.9%)	9 (10.2%)
17. Stand up for yourself when another kid in your class makes fun of you	11 (12.5%)	5 (5.7%)	15 (17.0%)	22 (25.0%)	18 (20.5%)	14 (15.9%)	3 (3.4%)
18. Help a student who is visiting your school for a short time to have fun and interesting experiences	8 (9.1%)	7 (8.0%)	13 (14.8%)	28 (31.7%)	16 (18.2%)	6 (6.8%)	10 (11.4%)
19. Join a school club and sports team	2 (2.3%)	8 (9.1%)	15 (17.0%)	4 (4.6%)	15 (17.0%)	15 (17.0%)	29 (33.0%)
20. Express your feelings to another kid	7 (8.0%)	7 (8.0%)	4 (4.5%)	14 (15.8%)	25 (28.4%)	21 (23.9%)	10 (11.4%)
21. Ask someone come to your house on a Saturday	14 (15.9%)	15 (17.0%)	7 (8.0%)	15 (17.0%)	13 (14.8%)	13 (14.8%)	11 (12.5%)
22. Ask someone to go for a school dance or movie with you	11 (12.5%)	11 (12.5%)	6 (6.8%)	16 (18.2%)	13 (14.8%)	14 (15.9%)	17 (19.3%)
23. Go to a party where you are sure you won't know any of the kids	31 (35.2%)	17 (19.3%)	14 (15.9%)	7 (8.0%)	13 (14.8%)	3 (3.4%)	3 (3.4%)
24. Ask another student for help when you need it	1 (1.1%)	7 (8.0%)	8 (9.1%)	16 (18.2%)	24 (27.3%)	17 (19.3%)	15 (17.0%)
25. Make friends with kids of your age	1 (1.1%)	0 (0.0%)	6 (6.8%)	5 (5.8%)	19 (21.6%)	23 (26.1%)	34 (38.6%)

Table 21 Distribution of Responses to the Items in the Rosenberg Self-esteem Scale (RSES)

Item	Strongly Disagree	Disagree	Agree	Strongly Agree
1. On the whole, I am satisfied with myself	1 (1.1%)	34 (38.7%)	49 (55.7%)	4 (4.5%)
2. At times I think I am no good at all	5 (5.7%)	37 (42.1%)	37 (42.0%)	9 (10.2%)
3. I feel that I have a number of good qualities	2 (2.3%)	5 (5.6%)	66 (75.0%)	15 (17.0%)
4. I am able to do things as well as most of other people	0 (0.0%)	27 (30.7%)	52 (59.1%)	9 (10.2%)
5. I feel I do not have much to be proud of	11 (12.5%)	39 (44.3%)	35 (39.8%)	3 (3.4%)
6. I certainly feel useless at times	18 (20.5%)	32 (36.3%)	29 (33.0%)	9 (10.2%)
7. I feel that I am a person of worth	1 (1.1%)	17 (19.4%)	59 (67.0%)	11 (12.5%)
8. I wish I could have more respect for myself	1 (1.1%)	9 (10.2%)	62 (70.5%)	16 (18.2%)
9. All in all, I am inclined to think that I am a failure	17 (19.3%)	51 (58.0%)	19 (21.6%)	1 (1.1%)
10. I take a positive attitude towards myself	5 (5.7%)	16 (18.1%)	57 (64.8%)	10 (11.4%)

Table 22

Frequency Distribution of Responses to Items in the Knowledge about Schizophrenia Scale (SKS)

Item	Correct	Incorrect	Not sure
(1) Schizophrenia means personality splitting.	37 (42.0%)	8 (9.1%)	43 (48.9%)
(2) The intelligence level of a schizophrenic patient is poorer than an average person.	45 (51.1%)	27 (30.7%)	16 (18.2%)
(3) Generally speaking, a schizophrenic patient has a greater tendency of hurting himself /herself.	16 (18.2%)	51 (58.0%)	21 (23.8%)
(4) The short-term memory of most schizophrenic patients has been damaged.	19 (21.6%)	33 (37.5%)	36 (40.9%)
(5) Generally speaking, schizophrenics patients are more aggressive.	12 (13.6%)	50 (56.8%)	26 (29.6%)
(6) Schizophrenic patients easily get worried.	6 (6.8%)	61 (69.3%)	21 (23.9%)
(7) Most schizophrenic patients have a suicidal tendency.	32 (36.4%)	19 (21.6%)	37 (42.0%)
(8) Most schizophrenics are having autism at the same time.	32 (36.4%)	7 (8.0%)	49 (55.6%)
(9) Most schizophrenic patients are poor in budgeting.	38 (43.2%)	11 (12.5%)	39 (44.3%)
(10) Most schizophrenic patients are usually lazy at work.	6 (6.8%)	65 (73.9%)	17 (19.3%)
(11) Schizophrenic patients often deliberate absurd behaviors.	22 (25.0%)	48 (54.5%)	18 (20.5%)
(12) Most of the schizophrenic patients are lacking of determination.	23 (26.1%)	24 (27.3%)	41 (46.6%)
(13) Most of the schizophrenic patients are stubborn.	33 (37.5%)	13 (14.8%)	42 (47.7%)
(14) Generally speaking, schizophrenic patients are poor in impulse control.	14 (15.9%)	54 (61.4%)	20 (22.7%)
(15) Most schizophrenic patients are socially withdrawn	25 (28.4%)	16 (18.2%)	47 (53.4%)
(16) It is more easily for the lower class / grassroots people to suffer from schizophrenia.	17 (19.3%)	38 (43.2%)	33 (37.5%)
(17) The chance of having schizophrenia is nearly the same between two sexes.	35 (39.8%)	10 (11.4%)	43 (48.8%)
(18) If your parents or siblings are schizophrenics, you have a higher chance of becoming one.	9 (10.2%)	51 (58.0%)	28 (31.8%)
(19) If the state of mind of a schizophrenic patient is more stable, he/she can voluntarily take less medicine.	44 (50.0%)	19 (21.6%)	25 (28.4%)

Table 22 (continued) **Frequency Distribution of Responses to Items in the Knowledge about Schizophrenia Scale (SKS)**

(20) Lower socio-economic status is one of the main causes for the relapse of schizophrenia.	20 (22.7%)	22 (25.0%)	46(52.3%)
(21) Experiencing stressful life events is one of the causes of schizophrenia.	67 (76.1%)	5 (5.7%)	16 (18.2%)
(22) "Largactil" and "Haloperidol" are the two commonly used medicine for schizophrenia.	1 (1.1%)	4 (4.5%)	83 (94.4%)
(23) Taking medicine over a long period of time is the only way to treat schizophrenia.	51 (58.0%)	17 (19.3%)	20 (22.7%)
(24) Losing appetite is one of the side-effects of anti-psychotic drugs.	25 (28.5%)	22 (25.0%)	41 (46.5%)
(25) Generally speaking, the possibility of relapse will be reduced with age.	13 (14.8%)	23 (26.1%)	52 (59.1%)
(26) Schizophrenics patients may seek medical consultation from the concerned clinic / hospital before the date of appointment if needed.	53 (60.2%)	8 (9.1%)	27 (30.7%)
(27) The regional hospitals managed by the Hong Kong Hospital Authority all provide bedspaces for psychiatric patients.	33 (37.5%)	14 (15.9%)	41 (46.6%)
(28) One may call the hot-line service of the Social Welfare Department if a mental patient relapses.	46 (52.3%)	10 (11.4%)	32 (36.3%)
(29) Most of the residents in the half-way house are male.	15 (17.0%)	18 (20.5%)	55 (62.5%)
(30) The Mental Health Association of Hong Kong has already started the "telephone inquiry service for mental health".	15 (17.0%)	3 (3.4%)	70 (79.6%)
(31) The service provided by day hospital has to be arranged by social workers.	22 (25.0%)	14 (15.9%)	52 (59.1%)
(32) The Labor Department has set up a Selective Placement Service to seek jobs for ex-mental patients with doctor's referral.	45 (51.1%)	7 (8.0%)	36 (40.9%)
(33) Ex-mental patients who have limited working capacity can attend the day training centre or sheltered workshop.	58 (65.9%)	2 (2.3%)	28 (31.8%)
(34) All schizophrenic patients are eligible to apply for Disability Allowance.	41 (46.6%)	11 (12.5%)	36 (40.9%)
(35) "Resources Centre" for the family members of the mental patients has not yet been commenced.	15 (17.0%)	3 (3.4%)	70 (79.6%)
Mean Response Rate	**32.0%**	**25.6%**	**42.4%**

Table 23

Frequency Distribution of Responses to the Behavioral Intentions Toward Ex-Mental Patient Scale (BIEMP)

Item	Yes	No
1. Work with an ex-mental patient	63(71.6%)	25(28.4%)
2. Work under an ex-mental patient	48(54.5%)	40(45.5%)
3. Hire an ex-mental patient	62(70.5%)	26(29.5%)
4. Invite an ex-mental patient to home	64(72.7%)	24(27.3%)
5. Have an ex-mental patient as your neighbor	71(80.7%)	17(19.3%)
6. Have an ex-mental patient in the same household	32(36.4%)	56(63.6%)
7. Marry an ex-mental patient	17(19.3%)	71(80.7%)

Table 24

Frequency Distribution of GHQ-30 (Likert)

Item	Much less than usual	Less than usual	Same as ususal	More than ususal
1. Could not concentrate	5(5.7%)	61(69.3%)	19(21.8%)	3(3.4%)
2. Lost sleep	54(61.4%)	26(29.5%)	8(9.1%)	0(0.0%)
3. Restless nights	52(69.1%)	18(20.4%)	14(15.9%)	4(4.6%)
4. Busy or occupied	20(22.7%)	49(55.7%)	17(19.3%)	2(2.3%)
5. Not out of house	11(12.5%)	49(55.7%)	20(22.7%)	8(9.1%)
6. Not managing well	1(1.1%)	53(60.3%)	31(35.2%)	3(3.4%)
7. Not doing things well	7(8.0%)	57(64.7%)	19(21.6%)	5(5.7%)
8. Not satisfied with tasks	11(12.5%)	63(71.6%)	12(13.6%)	2(2.3%)
9. No warmth/affection	13(14.8%)	60(68.2%)	14(15.9%)	1(1.1%)
10. Couldn't get on with others	12(13.6%)	60(68.2%)	12(13.6%)	4(4.6%)
11. Not chatting with others	10(11.4%)	48(54.5%)	23(26.1%)	7(8.0%)
12. Not playing a useful part	7(8.0%)	57(64.7%)	22(25.0%)	2(2.3%)
13. Could not make decision	8(9.1%)	58(65.9%)	20(22.7%)	2(2.3%)

Table 24 (Continued) Frequency Distribution of GHQ-30 (Likert)

14. Felt under strain	19(21.6%)	34(38.6%)	32(36.4%)	3(3.4%)
15. Could not overcome problems	17(19.3%)	44(50.0%)	24(27.3%)	3(3.4%)
16. Found life a struggle	37(42.0%)	20(22.8%)	27(30.7%)	4(4.5%)
17. Not enjoying activities	6(6.8%)	60(68.2%)	17(19.3%)	5(5.7%)
18. Taking things hard	8(9.1%)	68(77.2%)	10(11.4%)	2(2.3%)
19. Scared or panicky	41(46.6%)	26(29.5%)	10(11.4%)	11(12.5%)
20. Could not face problem	12(13.6%)	54(61.4%)	21(23.9%)	1(1.1%)
21. Felt everything on top	14(15.9%)	39(44.3%)	27(30.7%)	8(9.1%)
22. Unhappy or depressed	23(26.1%)	43(48.9%)	19(21.6%)	3(3.4%)
23. Lost confidence	38(43.2%)	36(40.9%)	9(10.2%)	5(5.7%)
24. Felt worthless	45(51.1%)	34(38.7%)	8(9.1%)	1(1.1%)
25. Felt life hopeless	39(44.3%)	41(46.6%)	2(2.3%)	6(6.8%)
26. Not hopeful about future	17(19.3%)	58(65.9%)	10(11.4%)	3(3.4%)
27. Not feeling happy	12(13.6%)	50(56.9%)	23(26.1%)	3(3.4%)
28. Nervous and strung up	30(34.1%)	29(32.9%)	22(25.0%)	7(8.0%)
29. Felt life not worth living	57(64.8%)	28(31.8%)	0(0.0%)	3(3.4%)
30. Too nervous	29(33.0%)	31(35.2%)	22(25.0%)	6(6.8%)

Table 25

General Health Questionnaire-30 (Based on 0-0-1-1 Scoring Method)

Case/Non-case	N	%
Case	45	52.9
Non-case	43	47.1
Total	88	100

Table 26

Distribution of Responses to the Items in the Hopelessness Scale (C-Hope)

Item	Totally disagree	Moderately disagree	Slightly disagree	Slightly agree	Moderately agree	Totally agree
1. Look forward to the future with hope and enthusiasm	2(2.3%)	4(4.5%)	5(5.7%)	25(28.4%)	29(33.0%)	23(26.1%)
2. Better give up because I can't make things better	21(23.9%)	38(43.2%)	5(5.7%)	20(22.7%)	1(1.1%)	3(3.4%)
3. Things are going bad but not forever	6(6.8%)	9(10.2%)	10(11.4%)	16(18.2%)	23(26.1%)	24(27.3%)
4. Can't imagine what my life would be in ten years	14(15.9%)	19(21.8%)	6(6.7%)	11(12.5%)	23(26.1%)	15(17.0%)
5. Have enough time to accomplish things	9 (10.2%)	5(5.7%)	15(17.0%)	18(20.5%)	23(26.1%)	18(20.5%)
6. Expect to succeed in what concerns me most	0(0%)	3(3.4%)	5(5.7%)	9(10.2%)	30(34.1%)	41(46.6%)
7. My future seems dark to me	42(47.7%)	22(25.0%)	8(9.1%)	7(8.0%)	6(6.8%)	3(3.4%)
8. Expect to get more good things in life	4(4.5%)	9(10.2%)	6(6.8%)	29(33.0%)	22(25.0%)	18(20.5%)
9. Not believe to get breaks now and in future	15(17.0%)	29(33.0%)	18(20.5%)	9(10.2%)	9(10.2%)	8(9.1%)
10. Past experiences prepare me for future	5(5.7%)	4(4.5%)	16(18.1%)	29(33.0%)	24(27.3%)	10(11.4%)
11. All ahead of me is unpleasant	33(37.5%)	16(18.2%)	22(25.0%)	8(9.1%)	4(4.5%)	5(5.7%)
12. Don't expect to get what I really want	27(30.7%)	15(17.0%)	20(22.8%)	14(15.9%)	6(6.8%)	6(6.8%)
13. Expect to be happier in future	0(0%)	1(1.1%)	5(5.8%)	13(14.7%)	33(37.5%)	36(40.9%)
14. Things not work out the way I want	4(4.5%)	18(20.5%)	9(10.2%)	19(21.6%)	27(30.7%)	11(12.5%)
15. Have great faith in future	2(2.3%)	16(18.2%)	11(12.5%)	22(25.0%)	26(29.5%)	11(12.5%)
16. Foolish to want anything	24(27.3%)	19(21.6%)	17(19.3%)	16(18.2%)	4(4.5%)	8(9.1%)
17. Very unlikely I will get satisfaction in future	20(22.7%)	28(31.8)	17(19.4%)	16(18.2%)	6(6.8%)	1(1.1%)
18. Future seems vague and uncertain	14(15.9%)	15(17.0%)	15(17.1%)	20(22.7%)	16(18.2%)	8(9.1%)
19. Look forward to good times	9(10.2%)	14(15.9%)	19(21.7%)	26(29.5%)	14(15.9%)	6(6.8%)
20. No use to try to get what I want	18(20.5%)	15(17.0%)	23(26.1%)	15(17.0%)	7(8.0%)	10(11.4%)

6.5 Interrelationships amongst stress, coping and mental health of the respondents

6.5.1 *Relationship between perceived stress and psychological well-being*

(a) *Relationship between perceived stress and GHQ-30*

As shown in Table 27, the perceived stress (PS-ALL) was correlated significantly with GHQ-30 (r=0.3299 for Likert scoring method; r=0.3296 for 0-0-1-1 scoring method). In other words, the higher the stress perceived by the respondents, the higher the GHQ-30. The sub-scales of the perceived stress (PS-MP, PS-PP and PS-SEC) were also significantly correlated with GHQ-30 (ranged from 0.2980 to 0.3323).

(b) *Relationship between perceived stress and hopelessness*

The significant positive correlation of perceived stress (PS-ALL) and hopelessness (r=0.2831) indicated that the more stress perceived by the respondents, the higher was the hopelessness level. All the sub-scales of perceived stress, especially PS-PP (with r=0.3728) had significant relationship with hopelessness. In other words, the higher the perceived stress, the higher was the level of hopelessness --- **Hypothesis 1 was supported.**

Since *higher perceived stress was found to associate with poorer mental health (higher GHQ score or higher level of hopelessness), the present findings provided support for Hypothesis 1.*

6.5.2 *Relationships between perceived stress and coping resources*

As shown in Table 27, the association between perceived stress and other major variables were presented as follows :

(a) *Relationship between perceived stress and social self-efficacy*

Perceived stress (PS-ALL) had not shown a significant correlation with social self-efficacy --- **Hypothesis 2 was not supported.**

(b) *Relationship between perceived stress and self-esteem*

Perceived stress (PS-ALL) was significantly and negatively correlated with self-esteem (r=-0.219). The subscale of perceived stress of psychological problems (PS-PP) was most highly correlated with self-esteem (r=-0.3566) indicating that the higher the perceived stress, the lower the score of the self-esteem scale --- **Hypothesis 3 was supported.**

(c) ***Relationship between perceived stress and knowledge about schizophrenia***

Perceived stress (PS-ALL) had a high correlation with knowledge about schizophrenia (r=-0.3519). The sub-scale of perceived stress of management problem (PS-MP) was most highly correlated with knowledge about schizophrenia possessed by the respondents. The correlation indicated that the more correct knowledge one has, the lower the perceived stress ---- **Hypothesis 4 was supported.**

(d) ***Relationship between perceived stress and behavioral intentions toward ex-mental patients***

Perceived stress (PS-ALL) had no significant correlation with behavioral intentions toward ex-mental patient (BIEMP), but the subscale of perceived stress (PS-PP) was moderately correlated with BIEMP (r=-0.22) ---- **Hypothesis 5 was not supported.**

(e) ***Differential effects of coping resources on perceived stress***

Table 28 revealed that significant relationship existed between knowledge about schizophrenia and perceived stress. It implied that the more knowledge about schizophrenia one possessed, the lower the perceived stress one experienced. On

the whole, these four variables of coping resources only explained 15.3% of variance in perceived stress.

1. **In summary, the above findings showed that *self-esteem was significantly associated with perceived stress* — Hypothesis 3 was supported.**

2. **The above findings also showed that *the correct knowledge about schizophrenia acquired by the adolescent children of schizophrenic patients was negatively correlated with perceived stress* — Hypothesis 4 was supported.**

6.5.3 *Relationships amongst the various measures of coping resources and psychological well-being*

As shown in Table 29, the findings are presented as follows:

(a) *Relationship between social self-efficacy and psychological well-being*

Social self-efficacy (SEFF) was negatively and significantly correlated with GHQ (r=-0.474 for Likert scoring method; r=-0.399 for 0-0-1-1 scoring method). In other words, the higher the social self-efficacy, the better the mental health --- **Hypothesis 6 was supported.**

From the same table, social self-efficacy (SEFF) was found to be negatively and significantly correlated with hopelessness (C-Hope). In

other words, the higher the social self-efficacy, the lower was the hopelessness --- **Hypothesis 6 was supported.**

(b) ***Relationship between self-esteem and mental health***

Table 29 also showed that self-esteem (RSES) was negatively and significantly correlated with general psychiatric morbidity (GHQ) and hopelessness (C-Hope). It means that the higher the self-esteem, the lower was the hopelessness --- **Hypothesis 7 was supported.**

(c) ***Relationship between knowledge about schizophrenia and psychological well-being***

It was found that knowledge about schizophrenia (SKS) had no significant relationship with psychological well-being in terms of GHQ scores and hopelessness --- **Hypothesis 8 was not supported.**

(d) ***Relationship between attitude toward ex-mental patient and psychological well-being (C-Hope)***

From Table 29, it was illustrated that attitude was negatively and significantly correlated with hopelessness (r=-0.2380). In other words, the more favorable the behavioral intentions, the less was the hopelessness --- **Hypothesis 9 was partially supported.**

(e) ***Differential effects of coping resources on psychological well-being***

From Table 30, it was illustrated that social self-efficacy (SEFF) and self-esteem (RSES) had significant impacts on GHQ and C-Hope. Overall speaking, those four variables of coping resources explained 48.5% of variance in GHQ and 40.6% of variance in Hopelessness (C-Hope).

Basically, the present findings provided support for the following hypotheses:

1. ***Higher social self-efficacy is associated with better mental health (lower score of GHQ and lower level of hopelessness)*** **— Hypothesis 6.**
2. ***Higher self-esteem is associated with better mental health (lower score of GHQ and lower level of hopelessness)*** **— Hypothesis 7.**
3. ***More favorable attitude toward ex-mental patient is associated with better mental health (lower level of hopelessness)*** **— Hypothesis 9.**

Nevertheless, the support for the last one was restricted to the measure of hopelessness only. Hypothesis 8 (*knowledge about schizophrenia is related to mental health*) was not supported by the present data.

The results of the findings concerning the hypotheses in the present study are summarized in the following table:

Hypothesis	Section	Table	Result
1. Lower perceived stress is associated with better mental health.	4.1	27	supported
2. Higher social self-efficacy is associated with lower perceived stress.	4.2.1	27	not supported
3. Higher self-esteem is associated with lower perceived stress.	4.2.2	27, 28	supported
4. More correct mental health knowledge is associated with lower perceived stress.	4.2.3	27, 28	supported
5. More favourable attitude toward the mental patients is associated with lower perceived stress.	4.2.4	27	not supported
6. Higher social self-efficacy is associated with better mental health.	4.3.1	29, 30	supported
7. Higher self-esteem is associated with better mental health.	4.3.2	29, 30	supported
8. More correct mental health knowledge is associated with better mental health.	4.3.3	29	not supported
9. More favourable attitude toward the mental patients is associated with better mental health.	4.3.4	29	partially supported

Table 27

Correlations amongst Perceived Stress and other Major Variables

	SEFF	RSES	SKS	BIEMP	GHQ(1) (Likert)	GHQ(2) (0-0-1-1)	C-Hope
PS-ALL	N.S.	-.219 *	-.3519 ***	N.S.	.3299 **	.3296 **	.2831 **
PS-MP	N.S.	N.S.	-.379 ***	N.S.	.3079 **	.2980 **	.2329 *
PS-PP	N.S.	-.3566 ***	-.2376 **	-.2200 *	.3236 **	.3106 **	.3728 ***
PS-SEC	N.S.	-.3058 *	-.3087 *	N.S.	.3125 **	.3323 **	.3074 **

* $P < 0.05$ ** $P < 0.01$ *** $P < 0.001$

N.S.: Non-significant

Table 28

Multiple Regression using Behavioral Intentions (BIEMP) Self-Esteem (RSES), Knowledge about Schizophrenia (SKS) and Social Self-Efficacy(SEFF) to predict Perceived Stress (PS-ALL)

	Perceived stress (PS-ALL)	
	β	R^2
1. BIEMP	0.024	
2. RSES	-0.168	
3. SKS	-0.362*	
4. SEFF	-0.033	0.153

$P < 0.05$

Table 29

Correlations amongst Coping Resources and Psychological Well-Being

	GHQ (Likert)	GHQ (0-0-1-1)	C-Hope
SEFF	-0.474 ***	-0.399 ***	-0.4190 ***
RSES	-0.649 ***	-0.371 ***	-0.5907 ***
SKS	N.S.	N.S.	N.S.
BIEMP	N.S.	N.S.	-0.2380 *

* P < 0.05 ** P < 0.01 *** P < 0.001

N.S.: Non-significant

Table 30

Multiple Regression using Behavioural Intentions (BIEMP),Self-Esteem (RSES) Knowledge about Schizophrenia (SKS) and Social Self-Efficacy (SEFF) Scores to predict GHQ-30 and Hopelessness (C-Hope) Scores

Dependent variables / Independent variables	GHQ		C-Hope	
	β	R^2	β	R^2
1.SEFF	-0.28 *		-0.83 *	
2.RSES	-0.54 ***		-0.49 ***	
3.SKS	0.12		-0.81	
4.BIEMP	-0.11		-0.21	
		0.485		0.406

* P < 0.05 ** P <0.01 *** P < 0.001

Chapter Seven

Discussion

Chapter 7 would focus on the findings of this study and its contribution to social work practice. Section 7.1 would cover the discussion of the psychometric properties of the tools employed in this study. This would be followed by the demographic characteristics of the respondents in Section 7.2. The respondents' perception of the existing services and expressed concern would be discussed in Section 7.3. The discussion on the nature of stress, coping resources and mental health of the respondents would be put in Section 7.4. The discussion on interrelationships amongst stress, coping resources and mental health of the respondents would be delineated in Section 7.5. The limitations of this study would be presented in Section 7.6.

7.1 Psychometric properties of the measuring tools

7.1.1 *Measurement of stress*

(a) *Stressor Scale (ST-ALL)*

The reliability statistics revealed that most scales employed in this study had satisfactory reliability. The Stressor Scale had high reliability (alpha=0.9365). The sub-scale of Stressor Scale -- Management Problems was highly reliable (alpha=0.9214), which reflected that the objective stressors existed in the families of

schizophrenic patients. In this sub-scale, half of the items were similar to the Chronic Strain Scale developed by Wong (1991). The second sub-scale of Stressor Scale -- Psychological Problems was constructed by the author and the reliability was acceptable (alpha=0.7825). However, there were a few observations which worth mentioning: i) item 31 " anxious about seeing a doctor or social worker" gained a low score. It was found from the findings that only a small proportion of adolescent children (12.5%) had seen medical professionals or social workers in the preceding 6 months. Therefore, most of the respondents had not experienced such feeling of anxieties and it might affect their response to this item, and ii) item 45 "complaints from neighbors" also had a low score in item-total correlation. Although Atkinson (1986) also reported that "complaints from neighbors" is a chronic problem in the family of schizophrenics, throughout the process of interviewing the respondents, it was impressed upon the author that the respondents' schizophrenic parents seldom caused nuisance or disturbance to neighbors.

The outcome of the reliability test reflected a reliable and internally consistent nature of the items in this scale. These findings compared favourably with those of similar scales obtained by Wong (1991) and Sun (1994). Since the measure of the stressors, especially their psychological problems, of the mentally ill's children in Hong

Kong is non-existent, this scale, having a satisfactory reliability status, can be utilized as a reference for the assessment tool in clinical practice or as a base for the development of related measures in future studies.

(b) ***Perceived Stress Scale (PS-ALL)***

As for the Perceived Stress Scale, the reliability was high (alpha=0.9483). Although the sub-scale of Perceived Stress -- Management Problems (PS-MP) also achieved high reliability (alpha= 0.9312), item 22 "waste money" had negative item-total correlation. It might be attributed to the small sample size in this study. In fact, "no control over spending" was found in some schizophrenics (Torrey, 1988) and therefore this item should still be included in the scale.

The sub-scale of Perceived Stress -- Psychological Problem achieved a higher reliability (alpha= 0.8456) than the sub-scale of Stressor Scale. It reflected that the perception of stress was closely related to the psychological conditions of the respondents.

The Stressor Scale and the Perceived Stress Scale in this study had higher reliability than the scales in a similar study of Wong (1991). Wong (1991) commented that some items in his scale might not be relevant to the respondents in Hong Kong due to cross-cultural difference in his study. Therefore, the items in this study had been carefully selected to suit the local context.

The findings of this scale also compared favourably with similar studies of Wong (1991) and Sun (1994). This scale was designed specifically to the children and the family members of schizophrenic patients and thus was more capable of assessing the accurate perceived stress of the respondents than the global stress measurement. Due to the satisfactory status of reliability, this scale may be further modified and utilized in other related studies.

7.1.2 *Measurement of coping resources*

(a) *Social Self-efficacy Scale (SEFF)*

The Chinese version of this scale was translated by the author. This scale achieved satisfactory item-total correlation (alpha= 0.8783). Each item gained an average weight of scores and no specially low score was found. It was considered that the face validity was accceptable (some experienced social workers had been consulted). Social self-efficacy, as a belief and expectation of one's personal skill in performing the specific social tasks, is a coping resource, and it reflects a person's mental health condition. This scale may be used as one of the assessment tools to understand the adolescents' deficits in social competence and problems in self-efficacy. This tool may also be employed for the social skills training groups and individual assessment in other settings like children and youth centres. For the medical social workers in a psychiatric setting, this tool may also be employed to

assess the social self-efficacy of the adolescent children of the mental patients before designing and arranging proper counselling or group programs for them. As the Chinese version of this scale and the research data on the construct of self-efficacy are not available in Hong Kong, it also has its contribution to the future studies of self-efficacy or social competence among Chinese.

(b) ***Rosenberg Self-esteem Scale (RSES)***

The Chinese version of this scale had been proved to be reliable in local study (Shek, 1993). In this study, RSES had lower reliability (alpha= 0.6459) which might be due to a small sample size. Item 8 "I wish I could have more respect for myself" gained a negative score. It was found in the interviews with the respondents that most of them took this statement as a positive one. Some respondents with high self-esteem would also "agree" or "strongly agree" with this item. Further exploration revealed that they tended to believe that everyone should respect himself / herself in order to gain the respect from others. In fact, Rosenberg (1965) also stated that an individual with high self-esteem respected himself while low self-esteem implied self-rejection. The Chinese version of this item might be modified or amended to reflect some negative meanings of this item. The author considered that this statement was still valid and could be included in the scope of self-esteem measurement.

In Hong Kong, the Chinese Self-esteem Scale was usually used as a measurement of mental health. In this study, the construct of self-esteem was studied as a coping resource and it was found to have significant correlation with social self-efficacy, attitude toward ex-mental patients and measures of psychological well-being. The outcome of this scale might be served as a reference to related studies in future.

(c) ***The Knowledge about Schizophrenia Scale (SKS)***

This scale was constructed by the author and it was found that the reliability was not high but acceptable. The validity of this scale was based on face validity (it was consulted with psychiatrists, social workers, psychiatric nurses and warden of half-way house). This scale had also shown to be internally consistent with acceptable alpha value (Cronbach coefficient alpha= 0.6830). In another study of the mental health knowledge of secondary school students in Hong Kong conducted by Shek (1990), reliability test showed that the Cronbach's coefficient alpha of the scale of Chinese Mental Health Knowledge Scale was 0.71. To ensure the reliability of this scale, test-retest reliability may be considered for future use. It may serve as an assessment tool in clinical practice when mental health workers extend their service to the family members of the schizophrenic patients. Due to the paucity of research data on knowledge about schizophrenia and the related services available in Hong Kong, this scale has its unique

contribution to literature. Future studies may be conducted to refine the scale.

(d) ***Behavioural Intentions Toward Ex-mental Patients (C-BIEMP)***

The reliability test revealed that the C-BIEMP was a reliable scale (Cronbach's alpha= 0.7560) which was similar to the results of Shek's (1988) study. Among the 7 items, item 6 "Have an ex-mental patient in the same household" was observed to have quite low item-total correlation when being compared with Askenasy's (1974) and Shek's (1988) studies. This result might be related to the small sample size. In fact, the teenage children of the schizophrenic patients might feel ambivalent that they considered the mentally ill should be accepted by the community, but living together with or getting married with the mentally ill was not their intentions.

7.1.3 *Measurement of psychological well-being*

(a) *GHQ*

The results of the reliability analyses showed that the Chinese version of the GHQ had high reliability (alpha=0.9160 for the Likert method; alpha=0.9043 for the 0-0-1-1 scoring method) which was a little higher than Shek's study (1987) of over 2,000 students in Hong Kong (alpha=0.88).

Item 4 "keep yourself busy and occupied" and item 13 "felt capable of making decision about things" had low item-total correlation. As for item 4, the Chinese version composed two meanings in the same statement which were "keeping yourself busy" and "adequate management of time". The author suggested that the latter meaning could be deleted to make the item appear to be in one direction. As for item 13, the low item-total correlation might be caused by small sample size. Anyway, the satisfactory reliability status of the Chinese version of this scale confirmed that it could be used among Chinese adolescents.

(b) ***Chinese Version of Hopelessness Scale***

Reliability statistics revealed that this scale had high reliability (alpha= 0.9007). Item 3 "When things are going bad, I am helped by knowing they can't stay that way forever" showed low item-total correlation. From the literal meaning of this statement, it was assessing one's faith toward overcoming the obstacles ahead. The low score might also be due to a small sample size in this study. However, this scale had been found to be reliable and internally consistent (Shek, 1987) and the present findings supported that the scale could be used in Chinese adolescents.

7.2 Characteristics of the respondents

7.2.1 *Sex, age and education*

A total number of 88 respondents had participated in this study. Males and females were in the proportion of 42 to 46. The mean age was 15.1. All of them were the natural / biological sons and daughters of their schizophrenic parents. Table 16 showed that most of them were studying in secondary school (69.3%). From a developmental point of view, the adolescents were at the transitional stage between early adolescence and adulthood. They started to experience more stress in addition to their normal grow-up difficulties in physical, psychological and social aspects (Rutter & Quinton, 1984).

7.2.2 *Housing condition, family size and family income*

As shown in Table 16, most respondents were living in public housing unit (69.3%), and had lower family income (less than $10,000, 88.7%) with a household of more than 4 family members (59.1%). Therefore, a significant proportion of families had a low socio-economic status. When a schizophrenic parent lost his/her working capability, the other parent would become the breadwinner of the family. If the schizophrenic parent was the father, the family would probably depend on the Comprehensive Social Security Assistance (CSSA) and the mother, being a full-time housewife, had to take care of

the family. The findings of this study also showed the impact of a congested living condition which was common in Hong Kong. In the study of Ngai, Law, Liu and Zhou (1994), congested living environment was a kind of external stressors. Shek (1988) also found that ex-mental patients would probably have difficulties in the high density living environment of Hong Kong.

7.2.3 *Religion*

Table 16 showed that over half of the respondents had religious belief and among those who had religious belief, most of them (about 70%) were Protestant. From Table 31 in Appendix C, the t-test showed the mean difference between the Protestant and non-Protestant ones on social self-efficacy. As observed, the Protestant respondents had higher level of social self-efficacy. It was assumed that many Protestant youngsters were members of fellowships in schools or in churches which facilitated them to interact with other young people through religious activities or recreational programs in a supportive environment where they could receive positive feedback in social interaction. Folkman, Schaefer and Lazarus (1979) regarded religious belief as a general belief which could affect a person's appraisal of stressors, and thus it might be a coping resource. Cheung (1992) also found that devoted Christians had more positive mental health than non-Christians.

7.2.4. *Caregiving role*

From the findings in this study, it was found that almost 20% of the respondents were the principal caregivers of their schizophrenic parents (see Table 16). In Wong's (1991) study about the caregivers of schizophrenic patients, respondents were mainly patients' parents and siblings, but children were not included in his study. In the current study, the figure showed that about one-fifth of teenage children of schizophrenic patients were bearing the burden of taking care of their ill parents who might have difficulties in general functioning in the family due to occasional unstable mental state. Therefore this group of children had their specific needs or difficulties.

7.3 Respondents' perception of the existing service and expressed concern

7.3.1 *Number of respondents who had visited social workers in the past 6 months and their satisfaction with the service of social workers*

From Table 17a, it was observed that only 12.5 % of respondents had accompanied their schizophrenic parents to visit social workers in the past 6 months. It showed that most of them might be preoccupied by their school life and activities, or they might simply not be the patients' caregivers, so it was not their responsibility to keep their parents' company to attend follow-up treatment. It reflected that most

of the respondents had not seen any medical social worker. Under such circumstances, even though many children might be experiencing considerable stress or in need of professional assistance, they would not be necessarily known to the medical social service. It implied that a large proportion of the respondents had not received direct social work service. The psychiatric social workers should therefore be more sensitive and initiative to detect the problems faced by the adolescents and then provide timely service for them.

7.3.2 The social services which were considered by the respondents as important for their schizophrenic parents

Although most of the respondents considered the medical social service as effective, it was doubtful if they really understood the service and the role of social workers as they seldom accompanied with their schizophrenic parents to visit medical social workers. On the other hand, there were still about 12 % of the respondents who did not consider the medical social services as effective (Table 17b). The presenting and underlying reasons deserve further studies.

Table 17c and 17d revealed that most respondents ranked the "psychological assistance/counselling service" and "mental health education" as the first and second priority services their schizophrenic parents needed. It reflected that the adolescent children of schizophrenic patients considered their mentally ill parents having

deficits/problems in some aspects of life. They believed that professional assistance might be beneficial to their schizophrenic parents in dealing with their psychological problems which might affect their social functioning and relationship among family members. In fact, the children were subject to the impact of parental behavior (Gecas & Schwalbe, 1983). The respondents expressed their hope that their ill parents could receive some more professional assistance, practical guidance, efficacious counselling and proper therapy, consequently, their insight might be enhanced, volition boosted, and also, their control of temper, emotions and symptoms improved.

Medical social workers in psychiatric settings are at the front-line to render immediate service to the mental patients staying in hospitals or attending out-patient clinics. The patients are in need of different kinds of services including tangible assistance as well as counselling service. Medical social workers have been entrusted with the tasks of sustaining the client's motivation to cope with the impact of the illness on physical, psychological and social aspects; rendering emotional support, restoring or enhancing their self-esteem; reinforcing adaptive behaviors and modifying or rectifying maladaptive ones; providing needed information and opportunities for choice and decision-making (Germain, 1984). In order to achieve these goals, different approaches of intervention may be adopted which include social skills training, life coping skills training,

cognitive behavioral therapy and other psychosocial approaches to explore, maintain, and mobilize patients' potential and abilities to cope with the mental illness and its impact. However, the reality in Hong Kong is that social workers have to face a heavy workload as well as a tremendous demand for services from clients. With limited resources, it is not easy for them to invest too much time on the patients and their families. As a consequence, counselling service and family therapy for the mentally ill clients are still far from adequate. It is apparant that the allocation of resources on casework counselling service especially in the psychiatric settings has a great need to be enhanced.

As perceived by the respondents, the next most needed service of their mentally ill parents was mental health education. It reflected the children's concern about the psychological well-bieng of their ill parents. The children also cherished a hope that their ill parents could benefit from relevant programs, so that they could have better self-management, gain more insight into their mental problems and achieve more promising prognosis. Hospital or clinic settings are also the proper places to render mental health education to the patients attending the clinics or staying in mental hospitals. Teamwork approach should be the best way to provide quality mental health care and education to the patients with a view to enabling them to return to independent living. In Hong Kong, collaboration among the professionals of Hospital

Authority and social workers has been promoted remarkably in recent years. More practical and creative programs (such as orientation programs for newly onset patients) and group activities (informational, supportive or therapeutic group) may be designed and arranged for the patients. It is hoped that a) more resources can be developed to support and to strengthen the mental patients' level of functioning and meet their needs in social, familial and employment aspects; b) the aim of psychiatric rehabilitation may be achieved so that mental patients may receive more training or acquire more skills to function effectively, and to manage the symptoms and side effects arising from the illness and medication properly.

7.3.3 *Social services most needed by the respondents*

From Table 17e and 17f, the respondents ranked the "education on management of psychiatric problems" and "training on stress management" as the first and the second priority services. As shown by the results, the respondents were most concerned about their ability and skills in the management of patients' problems at home. They might feel the need to equip themselves with adequate knowledge and techniques in dealing with the mental patients at different stages or facing patients' relapse. Actually, the management problems, psychological problems and social / economic costs have become daily hassles confronting them to a certain extent for some years. The

findings in this study showed that many of them were ready to receive proper training and education to enhance their coping ability in handling their schizophrenic parents' mental problems and their influence on the family. It appears that the adolescent children, who have to assume greater responsibility at home due to the specific family environment, understand their role in managing and helping their schizophrenic parents, so as to ameliorate the negative impact on the family.

From Table 17e, "Training on stress management" was the next main concern of adolescents (almost 30%). It meant that many adolescents had been very conscious about the stress they experienced and they were eager to improve their situation. In Hong Kong, many youngsters grow up in a congested, competitive and rapidly changing community with great vulnerability to the unfavourable influence. In addition to the general stress that they experienced in daily life, the adolescents who have parents with schizophrena may probably face more stress and pressure.

This study indicated that the adolescent children of the schizophrenic patients should receive more attention and services from the professionals. During the process of data collection of this study, the author interviewed a teenage girl who had experienced tremendous stress and depression in facing her schizophrenic father. She wept and voiced out her hatred, bitterness and grievances toward his hospitalized

father, who exhibited violence and caused much disturbance at home. Social workers should therefore be ready and sensitive enough to help those adolescents who needed support, understanding and effective welfare services.

In Hong Kong, the social stigma and prejudice against the mentally ill were still confronting their family members as well as the patients themselves. In the author's clinical experience, the adolescents with the mentally ill parents rarely sought assistance from the medical social workers. Most of the time, their problems drew professionals' attention when crisis occurred, such as patients' showing aggression, violence or relapse at home. From the findings in this study, about one-tenth of the respondents ranked the counselling service as their most needed service, about 22% of the respondents (see Table 17d) ranked it as second priority. However, only 12.5% (see Table 17a) had accompanied their ill parents to visit social workers in the preceding six months. The author believed that very few of them would draw the social worker's attention to their experienced stress and psychological struggles since the problems of the patients themselves were usually the core concern of the professionals.

In response to the passive role of the adolescents to resolve their own stress, it was interesting to explore the help-seeking pattern of the

adolescents in Hong Kong. Li and Ng (1992) studied the life stressors and help-seeking behavior of about 2,000 secondary school students in Kwun Tong District. They found that in the face of stress, students still tended to seek help from family and peers as priorities rather than from the helping professionals. In their study, only 1.4% of the students chose the school social worker as the helper whom they would first approach in times of crises. Since teenage children of the mentally ill are less likely to voice out their problems or turn to social workers for assistance, the social workers at front-line have to take more initiative and be more sensitive to identify their problems. Creer (1975) and Lefley (1989) also reported that some mental health professionals had not provided timely services to the desperate family members of the mentally ill. Therefore, early identification and intervention into their problems were of paramount importance in promoting primary mental health care.

7.4 Stress, coping resources and mental health of the respondents

7.4.1 Stress

(a) *Stressors faced by the respondents*

With respect to the research question about ***the types and frequency of occurrence of stressors faced by the adolescent children of schizophrenic parents (Research Question 1),*** the findings in this study revealed that stressors of management problems were most

frequently faced by the respondents. According to Table 18, symptoms like "sleeping disturbance" (item 10), "emotional disturbance at home" (item 2), and "throwing temper without reason" (item 1) occasionally / always became the stressors of a large proportion of respondents whose daily functioning might be affected. These findings matched with Waters and Northover's (1992) study which indicated that some schizophrenic patients caused moderate to severe hardship to their family members due to behavior which frightened them or caused tension in the family. The results in this study were more or less consistent with that of Wong (1991) who identified that "bizarre behaviors" and "fluctuation of emotions (e.g. temper tantrums)" were the most frequent stressors. However, some results of this study had discrepancies with the stressors suggested by Creer and Wing (1975) who considered that residual symptoms were most problematic to family members. They found that relatives living with people who had schizophrenia reported the following behavior as most common: 74% had social withdrawal (item 3, only 22.7% in this study) and 56% had underactivity (item 27, only 38.6% in this study). Under the congested and crowded living environment of Hong Kong, the schizophrenic patients inevitably had more social interaction with other people. Moreover, many schizophrenics still had to work to supplement the income of the family or had been arranged to work in sheltered workshops, they were exposed to an environment which maintained

their social interaction with others and thus had less social withdrawal and underactivity perceived by the children.

In this study, it was found that the adolescent children of schizophrenic patients were more sensitive to their parents' disturbance or bizarre behaviors at home. Actually from the author's clinical experience in psychiatric emergency or from the complaints of family members, it was found that schizophrenic patients' disturbing behaviors or aggression were considered to be most upsetting and threatening by family members. They needed support from the professionals in managing these problems although it was found that adolescent children had much tolerance to their schizophrenic parents.

Concerning the stressors of psychological problems, as illustrated from Table 18, over 40% of respondents identified that "feeling sad for the communication blockage with their mentally ill parents" (item 36) and "feeling ashamed of telling others about their mentally ill parents" (item 34) were two stressors confronting them the most. It suggested that those respondents were not satisfied with the parent-child relationship. They needed to know more about the nature of schizophrenia and the skills of interacting or communicating with a schizophrenic parent. With respect to the stressors of social and economic costs, over 45% identified that "taking up more housework"

(item 39), "facing the affected daily living" (item 42) and "experiencing financial difficulties" (item 41) were the crucial stressors. Some of them bore the extra burden of the family which might contribute to their difficulties in the aspects of academic performance, social life and normal development. These areas are worth further studies.

(b) *Perceived Stress*

With regard to the research question about ***whether the respondents had perceived stress and what type of perceived stress they experienced*** **(Research Question 2),** it was found that the greatest perceived stress experienced by the respondents in this study was the management problem of "patient's relapse of mental illness at home" (item 18). When the present findings were compared with Wong's (1991) study, item 18 did not appear in Wong's *perceived stress scales*. Moreover, the results indicated that the respondents' experienced stress was frequently generated from patient's throwing temper tantrum (item 1), emotional disturbance (item 2), bizarre thoughts (item 7), having hostile feeling toward others (item 13) and having suicidal thoughts (item 15). From these findings, only items 1, 2 and 7 matched with Wong's study. It was also found that the average perceived stress experienced by the adolescent children in this study was even greater than that of the caregivers in Wong's (1991) study. According to the present findings, over 40% of the respondents felt considerable or great

stress in "facing their mentally ill parent's relapse at home" (item 18) and "family's financial hardship" (item 41). However, from Wong's (1991) findings, the only one item that over 30% of the respondents rated as stressful was "frustration of emotion". Judging from the above findings, the adolescent children of schizophrenic patients had really experienced more stress than expected. In facing the burdensome problems in the family, they might be fighting the battle without adequate support from the environment. In fact, their 'other parents' might have been busily or exhaustibly engaged in providing care for the mentally ill parent, taking up more household tasks or working from dawn till dusk to earn the living for the family. The adolescent children were always considered by their parents as independent and capable of taking care of themselves. Moreover, they were treated as domestic helpers, baby-sitters and even caregivers of their schizophrenic parents. Their burden, emotions and needs were always neglected. However, they seldom voiced out their fluctuations and problems.

From the present study, being different from the suggestion of Creer and Wing (1971), it seemed that patient's residual symptoms were not the main concern or source of stress. Obviously these items were related to the strong negative emotions which caused much resentment or emotional feedback from family members. From the author's experience of working with those adolescent children of schizophrenic

patients, some of them had much bitterness and grievance toward the patients who had exhibited violence to them or other family members. Moreover, the patient's emotional impact on the adolescent was related to the patient's characters or personality which to some extent might exacerbate the disturbing symptoms.

Based on the findings in this study, the first rank symptoms such as hallucination, bizarre thought or delusion or depressed feelings of the patients had not been a major concern of the adolescent children. It seemed that they had more tolerance toward their parents' active symptoms. However, the patients' behavioural disturbance, aggression, fluctuating emotions, or uncontrollable acting out behavior during relapse were overwhelmingly stressful toward the teenage children. Concerning the problem of refusing medication of the schizophrenic patient, 42% of the respondents reported it as a frequent stressor, but only 21.6% of them regarded this stressor as stressful (see Table 19). When it was compared with the results of Wong's (1991) study, it was found that the perception toward the stressor of "refusing medication" was to a greater extent and more stressful in children rather than in caregivers (only 5.4%). It could be explicated that the children of schizophrenic patients might experience more stress in supervising the patients than the adult principal caregivers. Therefore, about 13.6% of

respondents felt guilty for not being able to spot the sight of relapse of their ill parents (item 35).

According to the results, it was also observed that in the perception of the adolescent children, the practical problems of "taking up extra household chores" (item 39) and "financial hardship" (item 41) were their main concerns. A question was raised that if the teenage children had to assume more household tasks, would other aspects of life be influenced? There were also 30% of the respondents felt stressful for the "unsatisfactory communication with their parents" (item 36) and this aspect should be attended by the psychiatric social workers. It was also found that the respondents generally had not experienced pressure from neighbors and friends as they rarely received complaints from their neighbors. As observed, many respondents had been living in the public housing units for years, and they had generally established a harmonious and supportive relationship with their neighbors who had a good understanding of the family environment of the mentally ill, and therefore had more acceptance to them. On the other hand, some other families paid a close vigilance on the mentally ill lest he/she should cause disturbance to others. It was actually related to the Chinese culture that people tend to conceal family affairs from outsiders.

The psychological problems which caused most stressful experience were the confusion caused by the queer behavior of the

parents (item 38), the sadness for communication blockage between the mentally ill parents and children (item 36), and the social embarrassment caused by the parents' socially unacceptable behavior (item 33). In view of the above psychological struggles experienced by the adolescent children of schizophrenic patients, they were a group of "at risk" clientele who needed professional assistance. The services suitable for this special group of clientele would be (i) specified counselling service to help them handle negative emotions and reconstruct their positive thinking patterns, (ii) personal developmental programs and group activities, (iii) psychoeducational programs including mental health and family life education, (iv) teaching relaxation exercises and reshaping their coping strategies and skills in the face of stressful situations and crises. With equipment of correct mental health knowledge and more awareness of their strengths and potentials, they could realize that they had the ability to perform their roles in family and in other social contexts.

Concerning the social and economic costs, the most stressful events perceived by the adolescents were financial problems (item 41), the disharmony caused by the family (item 43) and incresed responsibility in taking up housework (item 39). As mentioned by Hatfield (1978), financial difficulties were always associated with the caring burden for the schizophrenics. From the findings of this study

Hatfield (1978), financial difficulties were always associated with the caring burden for the schizophrenics. From the findings of this study (see Table 16), about 30% of the respondents' families were depending on the Comprehensive Social Security Scheme (CSSA) and over 30% of the respondents' family income was below $5,000. Actually the issue of the insufficiency of CSSA to meet the material and social needs of children of the deprived families had drawn much public attention. Psychiatric social workers should also be concerned about the welfare as well as the social needs of these children of schizophrenic patients under stress.

Being stigmatized as the children of the mentally ill, they may have a sense of inferiority and helplessness. The social workers of psychiatric setting, family services and schools should pay more effort to identify the stressors and the perceived stress of the adolescent children with a schizophrenic parent, especially their worries about the management of the problems caused by the mental patients. Moreover, social workers should also be alert of the over-burdened plight of some teenage children of schizophrenics. Early identification of problems and timely provision of services and education are the essential elements of helping the adolescent children as well as the caregivers of the mentally ill in an effective way.

7.4.2 *Coping Resources*

(a) Social Self-efficacy

According to the analysis of the data in this study, it was found that a high proportion of respondents had positive responses to the Social Self-efficacy Scale. It showed that most of them felt easy to complete the social tasks in many specific situations. According to their views, the easiest tasks were expression of opinions / joining discussion / sharing (items 2, 6), going out for activities / having fun with friends (items 13, 14, 22) and making friends with kids of their age (item 25). As shown by the results, the respondents seemed to have more confidence in getting along with their acquainted peers for fun or other activities, and many of them were also assertive enough to voice out their opinions and feelings. With respect to the research question about ***whether children of schizophrenic patients display any problem regarding social self-efficacy*** **(Research Question 3)**, some negative responses were investigated. From the findings, it appeared that "go to a party where you are sure you won't know any of the kids" was considered as the most uneasy task by about 70% of the respondents (those who rated "slightly possible to do", "moderately impossible to do" and "impossible to do" in the scale). Over 40% of the respondents felt uneasy to "start a conversation with someone they don't know well"

(item 1), and they found it not easy to "invite a friend to their house" (item 21). Moreover, over 30% of the respondents considered it not easy to "volunteer to help organize a school function" (item 8), "stand up for yourself when another kid in your class makes fun of you" (item 17). In sum, it was found that joining social groups / meeting a stanger(s) and achieving satisfactory public performance were considered to be the most uneasy tasks to complete. Moreover, they generally felt uneasy to invite a friend to their house. This might be due to their unwillingness to let their friends meet their mentally ill parents or see their unfavorable living environment.

Generally speaking, many respondents still maintained a satisfactory level of social self-efficacy which would have positive effect on their mental health (Connolly, 1989). It indicated that children living in a stressful family environment, like having a mentally ill parent, were not necessarily poor in social performance or vulnerable to distress. It reflected that good social integration might be a factor which buffered the effects of stress (Garmezy & Masten, 1986). It was also contradictory to the common belief that children of the mentally ill had problematic and poor development. It seemed that some children were resilient to the stress in their specific family environment. They appeared to have satisfactory level of social functioning. Table 31 also showed that more Protestant respondents than the non-Protestant ones

had higher scores in the social self-efficacy scale. As mentioned earlier, church activities might facilitate their social interactions in an environment with relatively more supportive feedback. Whether there were other factors contributing to the high level of self efficacy should deserve further exploration.

In conclusion, although many adolescents seemed to have satisfactory social efficacy, there were still some respondents who found it difficult to perform specific social tasks. It reflected that they might be in need of training in communication skills, assertiveness and public performance.

(b) ***Self-esteem***

With respect to the research question of ***whether the adolescent children of schizophrenic patients have problems regarding self-esteem*** **(Research Question 4)**, as illustrated from the findings, only about 60% of the respondents felt that they were satisfied with themselves. About 55% of them felt that they themselves have not much to be proud of (item 5), were useless at times (item 6), and about 50% felt that they were no good at all (item 2). It reflected that these respondents had limited self-acceptance to themselves and were not satisfied with their present status quo, personal quality and ability.

On the other hand, as observed from the responses, it was found that most respondents believed that they had a number of good qualities. However, it did not imply that they were satisfied with themselves. On the whole, the self-esteem of the respondents were not very high. It is suggested that psychiatric social workers may identify those adolescent children with poor self-esteem and design proper community center-based programs (to avoid the stigma effect in hospital / clinic setting) for them to improve communication skills and promote positive peer support, thereby enhancing their self-esteem.

(c) ***Knowledge about schizophrenia***

With respect to the research question about ***the quality of knowledge about schizophrenia and related services the children of schizophrenic patients have*** **(Research Question 5),** the low mean correct response rate (32%) and roughly 42% of "uncertain" responses in this scale reflected the adolescents' inadequate knowledge about schizophrenia, mental health and available services for the mentally ill in Hong Kong. The first fifteen items (Area 1) reflected the general observation and opinions of the respondents toward the mentally ill's emotions and behavior. The mean score for the correct responses in this session was 26.42% (ranged from 6.8% to 51.1%). The unsatisfactory results implied that the respondents might have prejudice or misunderstanding toward the nature of illness of schizophrenia. The

negative comments about the behavior of schizophrenics reflected the possible over-generalization of the symptoms and features of the illness. With reference to the findings found in the "Area 1", over half of the respondents considered the schizophrenics as being "prone to get worried" (69%), "impulsive" (61.4%), "self-harming" (58%), "aggressive" (56.8%), "absurd" (54.5%), "having poor memory" (37.5%) and "lower intelligence" (30.7%). It was unfortunate that a large proportion of respondents held such a negative view toward the schizophrenic patients. In view of the above, their understanding, acceptance and tolerance to their schizophrenic parents might be affected to a certain extent. They might have unconscious rejection toward their schizophrenic parents and hidden unwillingness to live with them. Unavoidably, the children always involved in the patients' symptomatic behavior. However, many of them did not accept such behavior in their everyday life (Clausen & Huffine, 1979). The attitude of children toward their schizophrenic parents and its impact on the parent-child relationship might be further studied.

As for the Area 2 of the scale (Item 16 -- 25), it was mainly concerned with the nature of the illness, the etiology and treatment of schizophrenia. The correct response rate ranged from 1.1% to 76.1% and the mean score was 36.59%. Item 22 , which was about the names of two common drugs, gained the lowest score. It reflected that they

might also have inadequate knowledge about the side-effects of drugs and result in misunderstanding toward patient's behavior.

Over half of them had the correct response to item 23 which implied that they knew that some other treatment approaches were beneficial to the patient's rehabilitation, but they might be lacking knowledge about the available services for the patients. A large proportion of the respondents gave correct response to item 21. It seemed they understood that stressful life events might be conducive to the onset of schizophrenia. They appeared to see the detrimental effect of stress and about 30% of them selected "training on stress management" as their most needed service (see Table 17).

Area 3 (item 27 --- 35) was about the available services for the mentally ill in Hong Kong. This sub-scale had the correct response from 17% to 65.9%, and the mean score was 38.96%. This outcome still reflected that the adolescents still had inadequate knowledge about the related services for the ex-mental patients. For example, over 47% of the respondents did not know that there was an emergency hot-line service provided by the Social Welfare Department (item 28) and another information hot-line provided by the Mental Health Association of Hong Kong (item 30). Moreover, over 80% of them were not aware of the commencement of resources centre for the family members (item

35). And also, there were over 45% of them who had little knowledge about the services of day hospital (item 31), the specified employment assistance (item 32) and the Disability Assistance (item 34). The findings clearly indicated that i) quite a significant proportion of respondents had inadequate knowledge or uncertain ideas about mental illness and relevant social services; and ii) a clear need to educate the youngsters.

The children of schizophrenics are no doubt an "at-risk" group in view of their specific family environment, negative parental impact or genetic vulnerability. Moreover, they actually have to face the burden of management problems, psychological problems and social / economic costs. Their lacking knowledge about the nature of illness, techniques of the daily management of mental patients, handling skills in case of crisis and information about the available services may give rise to their feelings of helplessness and loneliness in facing their parents' chronic illness and subsequent problems. As a matter of fact, the more correct mental health knowledge they acquired, the more competent they will be in facing and handling the problems which they may encounter in the reality. In addition, proper education may promote primary prevention in mental health and enhance the adolescents' psychological well-being. In Shek's (1990) study about the mental health knowledge of secondary students (mean response rate for correct answer was 38.4%), it was

found that a significant portion of the students was either ignorant or having misconceptions of mental health. Until now, it seems that the Education Department still has not had much improvement in promoting the primary prevention of mental health by arranging more teaching materials in the school curriculum. Moreover, the community-based educational programs are far from enough, and the scope and impact is limited. Thus, it is suggested that collaboration of the Education Department, Hospital Authority, Social Welfare Department and those non-governmental organizations providing mental health services should be enhanced to promote proper mental health education for children and youth.

(d) ***Behavioral intentions toward ex-mental patients***

With respect to the research question "***what the attitude of adolescent children of schizophrenic patients toward ex-mental patient is***" **(Research Question 6)**, from the results in this study, it was observed that most respondents were willing to work with and to hire an ex-mental patient, to invite him/her to home and have him/her as neighbor (ranged from 71.6% to 81.8%). It seemed that the respondents had a positive attitude toward ex-mental patient. However, it was ambivalent that the respondents, when they considered the occasions of having close and long-term relationship with the ex-mental patients, tended to show a negative response. Being a teenage child of a

schizophrenic patient, it was reasonable to expect that his / her mentally ill parent would be employed, accepted by others and not complained by neighbors. Their positive responses to the above items might be a reflection of their own need to be accepted by the community, friends and neighbors. However, in this study, it was surprised to find that about 80% of the respondents were not willing to marry an ex-mental patient, and about 64% of them expressed their unwillingness to live in the same household with an ex-mental patient. The outcome of item 7 "Marry an ex-mental patient" was even more negative than the findings of Shek (1988) whose target group was over 1,800 secondary school students. The results in this findings suggested that the children of schizophrenic parents might experience some sorts of impact which was conducive to their reluctance or even resentment to be closely related to the mentally ill. Despite some respondents appeared to be very accepting to their mentally ill parents, their affectionate ties to their parents and inevitable involvement in managing their parents' problems may bring them a certain degree of frustrations and emotional turmoils. Actually, more areas concerning the impact of parnetal mental disorder on the children may be explored so as to have more understanding of those children's crises, worries and psychological struggles. Then more effective services may be developed and arranged for them.

7.4.3 *Mental health of respondents*

(a) General Health Questionnaire

With respect to the research question about ***the mental health status of adolescent children with schizophrenic parents***, **(Research Question 7)** there were about 53% of respondents (based on 0-0-1-1 scoring method of GHQ-30) were considered as "at risk" cases (Table 25). In this study, from Table 24, it was found that the items which gained highest responses on the pathological direction were "felt under strain", (item 14, 39.8%) "felt everything on top" (item 21, 39.8%), "found life a struggle" (item 16, 35.2%), and "nervous and strung up" (item 28, 33.0%). It appeared that the stress was internalized and it was not explicitly manifested in work and their social life. The results matched with the focus of Rutter and Quinton's (1984) study which concluded that the features of mental illness would put children at psychiatric risk owing to the tremendous strains they experienced. When this result was compared with the outcome of Wong's (1991) study about caregivers under the 0-0-1-1 scoring method, the "case" of this study (52.9%) was higher than that of Wong's study (31.1%). Anyway, this result was lower than that of another local study about the adolescent (general population) mental health (Ngai, Law, Liu & Zhou, 1994) in which 78.6% of respondents were classified as "at-risk" cases, but the high rate of responses in their study was work- and problem-related rather than stress-related as found in this study. Since the cut-off

score still needed to be validated, the data would at best be regarded as tentative.

(b) Hopelessness Scale

As for the hopelessness scale, item 14 "things not work out the way I want" gained the highest negative response rate, followed by item 4 "can't imagine what my life would be in 10 years". It appeared that the respondents had more hopelessness toward the uncertainty of the future rather than the issues concerning happiness (item 11 and 13) and success (items 2, 5 and 8). Shek (1993) also found that the Chinese version of Hopelessness Scale (C-Hope) correlated more highly with the Depression Sub-scale of the GHQ. In this study, the author mainly studied the correlations between the coping resources and Hopelessness Scale / GHQ, but the inter-relationships among the measures of psychological well-being were not explored.

7.5 Findings on relationships among major variables

7.5.1 *Relationship between perceived stress and psychological well-being*

From Table 27, it was shown that perceived stress had significant relationship with mental health (both GHQ-30 and Hopelessness). Actually, from many studies, stress had been proved to be associated with increased risk for mental problems. Moreover, perceived stress had been found to better

predict the psychological well-being than objective stressor (Felner, 1985; Lazarus & Folkman, 1984).

Among the items of perceived stress, the most stressful items rated by the respondents included patients' relapse at home, emotional disturbance, throwing temper tantrums and hostility would probably disrupt patients' relationship with other family members. Epstein (1983) had suggested that success in social relations, and success in establishing satisfactory intimate relationships were significantly associated with mental well-being. Moreover, those items of perceived stress were related to threats which, in Lazarus and Folkman's (1984) conception, were harms and losses. They were characterized by negative emotions such as fears, anxieties and anger. In other words, poor parent-child relationship and threats caused by patients' acting out behaviour would be associated with poor mental health.

7.5.2 *Relationships between perceived stress and coping resources*

Among the four coping resources, *social self-efficacy* and *attitude toward ex-mental patients* were not significantly correlated to perceived stress (see Table 27). It seemed that the stress was not predictive of the respondents' social competence; moreover, attitude was not predictive of perceived stress. In fact from Table 19, only roughly 20% of the respondents felt stressful ("considerable" or "great" perceived stress) for the influence of social life

(item 44) and a large proportion of the respondents had satisfactory level of social self-efficacy (see Table 20). A possible explanation was that other environments outside the family such as schools, religious institutions, youth centres, etc. might foster the respondents' social competence. As for the attitude toward the ex-mental patients, it was expected that favourable attitude should be associated with lower perceived stress. The insignificance (shown in Table 27) might be due to the small sample, or basically the attitude itself was not predictive of perceived stress. Further exploration of the other attribution factors may be put into future research.

The present study only indicated that *self-esteem* and *correct knowledge about schizophrenia* had significant relationship with perceived stress. That means higher self-esteem would be associated with lower level of perceived stress. Among the items of perceived stress, those with high prevalence rate were management problems. The most stressful ones were "patients' relapse at home", "emotional disturbance", "temper tantrums" and "hostility" (see Table 19). A person with high self-esteem felt good about himself, considered himself worthy and useful (see Table 21). When the adolescent children of the schizophrenics were facing the management problems caused by their schizophrenic parents, those with lower self-esteem tended to have self-rejection and self-dissatisfaction (Rosenberg, 1965) and therefore they tended to consider the acting out or hostile behavior of their parents as a kind of rejection to them. Owing to their negative thinking pattern,

they would be more likely to be affected by their mentally ill parents. Conceiving that they were not as good as others or not competent enough to complete tasks or feeling themselves useless, they would feel the burden of the management problems more overwhelming and pressing than those who had higher self-esteem. Their previous failure experience in handling the problems caused by their mentally ill parents would also aggravate their feeling of uselessness. As stated by Tennen and Herzberger (1987), people with lower self-esteem tended to make more internal causal attributions for their failure and then caused more self-blame.

The results in this study also revealed that the sub-scale of perceived stress of psychological problems was most highly correlated with self-esteem. Among the psychological problems (see Table 19, items 31-38), the impact of "anxieties", "embarrassment", "shamefulness", "guilt", "sadness", "annoyance" and "confusion" were more likely to be experienced by those with low self-esteem because of their own negative self-evaluations.

Apart from self-esteem, correct mental health knowledge also had significant relationship with perceived stress. The respondents having gained low scores in this scale reflected that they had misconception and misunderstanding toward mental illness and mental patients as well. Consequently, they would tend to reject or blame the mental patients based on their prejudice or negative beliefs about them (Socall & Holtgrave, 1992). Lacking correct knowledge implied that they did not have enough

understanding of the nature of the mental illness and would probably have more anxiety toward the "unpredictability" of the relapse of mental illness. As stated by Folkman, et al (1979), the lack of information would cause ambiguity and uncertainty which in turn increase the individual's perceived stress.

7.5.3 *Relationship between coping resources and mental health*

From Table 29, it was observed that social self-efficacy and self-esteem were significantly correlated to mental health (CHI-30 and C-HOPE), and attitude toward ex-mental patients was restricted to have significant relationship with the measure of hopelessness only, whereas mental health knowledge was not significantly correlated with mental health. These results supported Connolly's (1989) notion that social self-efficacy was a contributor to mental health. He further elaborated that social self-efficacy was not correlated with psychiatric problem, but it was predictive of particular symptoms of disturbance.

Concerning the relationship of self-esteem with mental health, Roberts and Monroe (1992) suggested depression was related to self-esteem. Rosenberg (1979) also stated that the causal relationship between self-esteem and depression was bi-directional. The results in this study supported the above statements.

Further analysis of the findings in this study revealed that attitude toward ex-mental patients had only a moderate correlation with hopelessness. This results also echoed Norman and Malla's (1983) assertion that attitudes toward mental illness was related to social acceptability and overall optimistic or positive view toward mental illness. As a matter of fact, an optimistic view would probably be related to a sense of hope. Concerning the relationships between the knowledge about schizophrenia (SKS) and the psychological well-being (C-Hope and GHQ), it was found that their correlations were insignificant which was contradicted to the author's hypothesis. Actually, this scale has its limitations and more refinement would be needed for further studies.

7.6 Limitations

7.6.1 *Use of variables*

Due to a paucity of research on this topic in Hong Kong, there is no data available for the mental health status of adolescents with schizophrenic parents. This study, as a start, explored the personal resources in coping with the specific stressors which they encountered in family. However, it only explored a few variables and the findings did not constitute proof of causal effects. Refering to Table 30, the multiple regression using coping resources to predict GHQ-30 and Hopelessness showed that all variables explained 48.5% of variance in GHQ-30 and 40.6% of hopelessness. It was speculated that some other variables such as

parenting style, family environment, academic achievement, social support, interpersonal relationship, etc. might be influencing the adolescents. Therefore, other variables deserve exploration to see their impact on the psychological well-being of the adolescents in future studies.

7.6.2 *Sampling*

The present study was conducted by using a non-probability sampling method. Theoretically, the best way of achieving probability sampling is by random sampling. Due to the difficulty in getting a sampling frame for all the schizophrenic parents with adolescent children in Hong Kong, the present sampling method mainly depended on the availability of respondents.

Moreover, sampling bias might exist since most of the present samples were referred by medical social workers in out-patient clinics and psychiatric hospitals. As most of the patients were the recipients of social services, it reflected that the patients were in need of assistance in their social, psychological, housing or financial aspects. It seemed that these families might come from the disadvantageous part or under-privileged population of the community and may be facing more strains in life. On the other hand, the other perspective is that the families receiving social services had been bolstered and supported in some ways. No matter which

perspective one takes, it seems that the present sample has its limitations and deficits. Actually, some families with schizophrenic patients may have encountered a lot of stressors and problems, but they are not known to the medical social service. In fact, those schizophrenic parents with adolescent children who were not the customers of social services did not participate in this study. As such, it seemed that this study only examined a portion of the full impact that might have on mental health outcome of the respondents. And also, the representativeness and generalization of the samples to the whole population of this target group was limited.

Since the age of the respondents in this study was ranged from 12 to 19, a question was raised: "would the respondents at early adolescence have any difficulty in completing the questionnaire?" Although they appeared to understand the meaning of all the statements in questionnaires during the interviews, a small proportion of younger respondents, who were still in primary schools, might have difficulties to conceptualize some abstract ideas and concepts in the contents of measuring instruments. Moreover, some respondents in this study were siblings in the same family. Whether these respondents had different responses to the stressors, perceived stress and mental health status or whether they had different coping responses were worthwhile to study and make a comparison. However, this aspect had not been further explored due to the time constraint.

7.6.3 *Data Collection*

Due to the limited time and resources, this research was conducted as a cross-sectional study. In fact, a longitudinal study would be more capable of examining the causal effects of coping resources or other contextual factors on mental health before and after the occurrence of the specific stressors.

7.6.4 *Measuring Instruments*

The measuring instruments employed in this research were borrowed from Western culture and the Chinese versions of these scales such as Rosenberg Self-Esteem Scale (RSES), Behavioral Intentions Toward Ex-Mental Patients (BIEMP), General Health Questionnaires (GHQ-30), Hopelessness Scale (C-Hope), had been found to have high internal consistency and they yielded high validity. However, due to the cultural difference, its reliability and validity, when used in this target group, needs further demonstration. The scale of Social Self-Efficacy (SEFF) was translated by the author and its reliability and validity were satisfactory, but it still deserves further exploration in the local context. Moreover, the self-constructed Knowledge about Schizophrenia Scale only has acceptable item-total correlation in the reliability test in this study, thus there is a need to further refine this scale and have more comprehensive validation of this version in future empirical studies.

Chapter Eight

Conclusions and Recommendations

8.1 Conclusions

The present study was conducted to examine the stressors, perceived stress, coping resources and mental health of the adolescent children of schizophrenic patients and to explore the relationship among these variables. A total of 88 respondents had participated in this study and a structured questionnaire with sound psychometric instruments had been administered to them.

This is a pioneer research to study the children of the mentally ill in Hong Kong and it is hoped that the findings from this study can help the front line service providers to pay more attention to the children of the mentally ill. In response to the research questions and hypotheses highlighted in Chapter 4, the major findings and conclusions are presented as follows:

(1) Stressors of management problems were most frequently encountered by the respondents. Over 45% of the respondents expressed that their schizophrenic parents frequently displayed *sleeping and emotional disturbance, temper tantrums, idleness at*

home, relapse at home, depression and bizarre thoughts and unwillingness to do the housework. Regarding the stressors of psychological problems, over 40% of the respondents *felt sad for failing to communicate clearly with their schizophrenic parents , and feeling ashamed of telling people about his/her schizophrenic parents.* As for social / economic costs, over 45% of the respondents faced the stressors of *more housework, disrupted daily routines, financial problem and disagreement among family members.*

(2) Concerning the perceived stress of the respondents, roughly 40% of respondents experienced considerable or great stress when *handling the patients' relapse of mental illness at home.* About 30% of respondents felt stressful in patients' *emotional disturbance, temper tantrums, bizarre thoughts, hostility to others, disturbing behavior at home and unwillingness to do housework.* As for the psychological problem, roughly 30% of respondents *felt confused to face the unusual behaviors of the schizophrenic parents.* Regarding the social / economic costs, about 40% of respondents experienced stress from *financial problem*, roughly 35% of them felt stressful about *disagreement in the family* .

(3) Many respondents had satisfactory level of social self-efficacy in their response to most of the 25 items in the scale. However, more than 40% of respondents had difficulties in some social situations like "*attending a party where he/she did not know anybody, starting a conversation with somebody not acquainted with and asking someone to his/her house*".

(4) Concerning self-esteem, a significant proportion of respondents (over 40%) rated in the negative direction in the scale. They considered themselves *not competent as others, not satisfied with themselves, feeling worthless and useless at times*. When being compared with social self-efficacy, it was found that high level of social efficacy did not necessarily imply to have high self-esteem.

(5) Regarding the respondents' knowledge about schizophrenia and available services for them and their mentally ill parents, the findings indicated that the mean correct response rate was only about 32% and the mean uncertain response rate was roughly 42% . It showed that a large proportion of respondents had *misconception and misunderstanding toward schizophrenia*. It suggested a clear need to strengthen the mental health knowledge of the youngsters in Hong Kong.

(6) With reference to the attitude toward ex-mental patients, it was found that a high proportion of respondents in this study showed their acceptance toward mental patients in working relationship or as neighbors. However, they reported an unfavorable attitude toward having a closer relationship with mental patients, such as "*living in the same household* " or "*marrying an ex-mental patient*". The findings reflected the inner perception of mental illness by the respondents, and illustrated that they had genuinely limited acceptance to their mentally ill parents. Moreover, there are probably some practical and psychological problems existed in their getting along with their ill parents.

(7) Regarding the mental health condition of the respondents, it was found that roughly over 50% of respondents were considered as "at risk" of having poor mental health. With respect to hopelessness, although a large proportion of respondents showed positive responses, some items indicated the feelings of pessimism and uncertainty, i.e. "*Things not work out the way I want*" and "*Can't imagine what my life would be in 10 years*" which had the negative response rate of over 50%.

(8) With reference to the perception of the respondents toward the medical social service, most of them considered the service effective while roughly 12% considered it ineffective.

(9) Concerning the expressed needs of the respondents, about 50% of them considered their parents need some *psychological assistance /counselling service*, while the second priority service was *mental health education*. With respect to the respondents' own needs, most of them had similar response rates on the options of "*education on management about psychiatric problems*" , "*training on stress management*" and "*social skills training*" as their most needed services .

(10) The findings showed that perceived stress was significantly correlated with mental health (Both GHQ-30 and Hopelessness Scale).

(11) Regarding the relationship between coping resources and perceived stress, it was found that only *self-esteem* and *mental health knowledge* showed significant and negative relationship with perceived stress. The present study indicated that *social self-efficacy* and *attitude toward ex-mental patients* did not have influence on the perceived stress.

(12) With reference to the relationship between coping resources and mental health, it was found that *social self-efficacy* and *self-esteem* were significantly correlated with measures of mental health (GHQ-30 and Hopelessness Scale); whereas *attitude toward ex-mental patients* was restricted to be significantly correlated with the measure of hopelessness only.

8.2 Recommendations

8.2.1 *Education on management of problems arising from mental patients*

Based on the findings in this study, the first priority service the respondents needed most was "education on the management of problems arising from mental patients". It reflected that the respondents were ready to learn more about the knowledge and skills in handling the problems caused by the mental patients at home, especially the measures of crisis intervention and the utilization of available social services including the hot-line service (almost half of the respondents did not know or were not sure about the Social Welfare Department's hot-line service for emergency cases). In order to promote the mental health education for the patients and their family members, some educational programs may be most conveniently organized and arranged

through the collaboration of medical professionals and social workers in the psychiatric settings.

8.2.2 *Training on stress management*

According to the findings of this study, about 30% of the respondents ranked "Training on stress management" as the first priority service and about 40% of them ranked it as the second priority service they needed most. There is a clear need to provide stress management training programs for the adolescent children of the patients. Besides teaching them relaxation exercises, the more effective approach may be i) reshaping their coping activities, ii) reconstructing their cognitive strategies in the appraisal and re-appraisal of the environmental demands, and iii) the better utilization of their coping resources. Meanwhile, social workers of psychiatric clinics, family services, family life education and schools may identify this group of clientele and render them proper services and programs in order to mobilize and maintain their coping efforts.

8.2.3 *Social skills training*

From the present findings, it was indicated that roughly 20% of the respondents ranked interpersonal skills training as the first priority service they needed the most. It reflected that those adolescents might encounter some sort of difficulties in their social interaction. In fact, the results on the social self-efficacy showed that over 30% (ranged from roughly 32% to 70%) believed that they were incompetent in a few social situations. In view of the important

contribution of social self-efficacy to mental health, enhancing the youngsters' self-efficacy through group social skills training in different settings like clinics, schools and youth centres may be adopted. The emphasis may be on vicarious learning, modelling and reinforcement process which serve to boost their sense of success in social transactions.

8.2.4 *Special counselling service*

Although there was only about 10% of the respondents ranked the counselling service as their most needed service, it did not undermine its importance. The findings in this study showed that only 60% of the respondents were satisfied with themselves and over 50% of them felt themselves useless and worthless at times (low self-esteem). Moreover, over 50% of them were classified as "at risk" for mental health problems (anxiety, depression, inadequate coping, interpersonal dysfunctioning and sleep disturbance). The adolescent children have a need for professional assistance in resolving their inner negative emotions, but their help-seeking pattern may hinder them to seek counselling service on their own. The social workers may then take an initiative step to reach out to this group of clientele for proper intervention and service.

Group work is an effective means to help those adolescent children of schizophrenic patients. Through the small group approach, a supportive network for them may be developed and it can help strengthen their coping

ability to their family situation. Self-help groups may be organized for them in psychiatric settings, family services centres, schools, community centres or on a community-wide basis. Special programs and groups can also facilitate them to achieve better self-understanding and to get more opportunities to channel their emotions. Moreover, through these programs their self-esteem may be enhanced and in turn, their mental health is likely to be promoted .

8.2.5 *Mental health education for the patients and their family members as well*

From the findings of this study, it was found that roughly 10% and 36% of the respondents ranked "mental health education" as the first and second priority services needed by their schizophrenic parents. Moreover, roughly 34% and 15% of the respondents considered "Education on management of Psychiatric problems" as the first and second priority services which were needed by them. These results reflected that the respondents ensured the importance and benefits of the mental health education to their ill parents and themselves as well.

The present findings also revealed that about 40% of respondents frequently faced the stressor of feeling ashamed of telling people about their schizophrenic parent, and about 34% felt embarassed to attending social events with his/her schizophrenic parent. More unexpectedly, about 80% of respondents reported that they were not willing to marry an ex-mental patient,

and roughly 60% of them were not willing to have an ex-mental patient in the same household. The results from the Knowledge about Schizophrenia Scale also showed that most of the respondents had misconception and misunderstanding about schizophrenia and schizophrenic patients as well. These findings reflected that there is a strong need to promote mental health education for both the schizophrenics and their family members so as to enhance the patients' ability in self-management and promote the understanding and acceptance of family members toward patients. Organizing seminars or related educational programs for the family members especially teenage children was also important to help them adjust to the mental illness of their parents.

From the author's experience, the effect of organizing joint functions with the medical professionals to arrange orientation groups or small group discussion for the relatives of schizophrenics in the medical setting was found to be very encouraging and meaningful. Such programs with a couple of brief sessions might be specially arranged for the teenage children of the mentally ill in which professional views and children's feedback may be exchanged. Moreover, educational programs such as crisis management or skills in facing the relapse of their parents not only help to equip them with proper knowledge, but also enhance their competence in handling the problems caused by their schizophrenic parents. There is no doubt that more efforts should be paid to promote this kind of service which should be expanded to the community level.

8.2.6 Public education

The negative perspectives of the respondents in the above findings also reflected that the public rejection and distortion toward mental patient were common. Under such circumstances, education about mental illness and mental health seems to be very essential to both the public and the family members of the mentally-ill so as to enhance their knowledge and acceptance toward the ex-mental patients. Public education such as carrying out more publicity work in the local community, launching mental health week / month, and having more promotional programs on mass media would be helpful. Publicity on the mental health services provided by both the government and the non-governmental agencies could also make the services more familiar to the public. The last but not the least, the primary and secondary school curriculum should put more emphasis on education about mental health. Teaching the students the correct knowledge about mental illness and mental patients should be promoted as a kind of primary prevention against mental health problems of the youth. Moreover, mental health education should also emphasize the positive attitude toward mental patients. Especially, more efforts should be paid to help the adolescent children of schizophrenic patients improve their attitude and acceptance toward their mentally ill parents since roughly 60% of them reported that they were not willing to live with a mental patient (it might include their own schizophrenic parents). Education is considered as an effective way to promote favourable attitude which is also

found to be a contributing factor for better mental health (in terms of lower level of hopelessness) in this study.

8.2.7 *Promotion of teamwork approach among different professionals*

Better cooperation among professionals of different disciplines can help both the patients and their family members to adjust to the difficult situations stemmed from the mental illness. As collective wisdom is preferable to individual judgment, the interdisciplinary sharing and co-operation among different professionals may build up an integrated diagnosis and to formulate a dynamic plan for the total rehabilitation of the patients and their family. The collaborated effort may provide broader perspective in care provision and continuity of care for the patients as well as their family members. When the patients are provided with quality mental health service, their family members including the adolescent children may feel more relieved. Moreover, with the multi-disciplinary approach, the service may be more program-centred instead of case-centred alone. The patients as well as the family members should be included in the programs.

8.2.8. *Co-operation among social workers and special training for service providers*

In addition to the collaboration with other disciplines, the social workers of different fields, having unique perspectives, may try their best to utilize their own strengths and available resources to provide the efficacious services for

the mental patients and their family members after identifying their specific problems. For instances, i) the medical social workers, besides concentrating their efforts on the social adjustment and welfare of the patients, may pay more attention to the family members especially the adolescent children who are vulnerable to the mental health problems; and also, their role as an advisor, educator, facilitator and coordinator may be strengthened not only in the medical settings, but also through more interaction with the family members during home visits or family therapy approach; ii) the family caseworkers, bearing in mind that the children of the mentally ill may be exposed to a lot of stressors and experience considerable stress, may provide some more outreaching and in-depth services to them; iii) the family life education workers may identify these families in the neighborhood and provide special programs for them with the emphasis on the parent-child communication and interaction (almost 30 % of the respondents in this study reported that they perceived it stressful for being incapable of communicating clearly with their schizophrenic parents); iv) the school social workers can act as counsellors and supporters to the students who have parents suffering from mental problems; moreover, organizing supportive programs in school, such as running social skills and stress management training classes, and mobilizing support from the classmates and teachers can help to strengthen the teenage students' coping ability.

In order to achieve the goal of better co-ordination and effective utilization of limited resources, mutual referral system and joint efforts in running programs would be worthwhile to promote. Furthermore, giving mental health service providers and teachers more relevant training is particularly important. Information about mental health and methods in handling the mentally ill may then be conveyed to the adolescent children to help them detect and manage the problems effectively at an early stage. Meanwhile, the Education Department should also provide adequate support to both the schools and students, especially in student assessment or treatment.

8.2.9 *Community support service and utilitarian support*

(a) *Financial assistance*

More financial support to the families with schizophrenic patients should be maintained and improved as most of the families usually suffered from financial hardship (about 30% of the respondents were CSSA customers, and roughly 40% of them had considerable or great perceived stress on financial problem). Additional allowance from the Comprehensive Social Security Assistance Scheme can be given to such deprived families to improve their quality of life.

(b) *Special home help /family aid service*

Supportive service such as home help / family aid service can also be strengthened to help alleviate the children's burden in the

household management especially when their schizophrenic parent is hospitalized or when their schizophrenic parent's mental state is unstable or general functioning becomes poor.

(c) ***Outreaching psychiatric service / Community nursing service***

Moreover, community nursing service and outreaching psychiatric service can certainly release the burden of the family members if their schizophrenic relatives are not willing to have medical consultation. Setting up crisis or hot-line service for the patients or the family members for emergency use or consultation may also provide immediate help to them in the face of crisis situations.

(d) ***Volunteer service***

The development of volunteer scheme to help the family of the mentally ill in sharing household chores or linking the family with the community supportive network is likely to alleviate the family members' burdens, especially during the patient's hospitalization.

(e) ***Aftercare service team***

Strengthening the aftercare service (emphasizing on family-oriented work) for the ex-hospitalized patients can also establish better supportive network for the family members. Family therapy for the

families of schizophrenics is also a rewarding approach. As this kind of service is not available in Hong Kong, a pilot project is worth trying.

(f) ***Social club for ex-mental patients***

Presently, the service of social club for the ex-mentally-ill is more patient-centred than family-centred. It is suggested that this service may be expanded so that family members especially the schizophrenic patients' children can also attend the club where some special social, supportive or recreational programs or small groups may be arranged for them.

(g) ***Respite service***

In view of the findings that almost 20% of the respondents were the principal caregivers of their schizophrenic parents and almost 40% of them felt stressful for taking up more housework, respite service may be considered to develop by expanding the present half-way house service, so that the family members especially the caregivers of the mental patients are able to have a break which is important for maintaining their psychological well-being and regaining their strength to take care of the patients. As this sort of service is not available in Hong Kong, it is worthy for the government and the mental health service agencies to promote and implement it and pioneer project may be started first.

8.2.10 *Concluding remarks*

Conclusively speaking, the above suggestions are aimed at better utilization of the community and professional resources to provide efficacious services to the mental patients and their family members, especially the adolescent children. The basic rationale is that enhancing the personal coping resources of the adolescent children of schizophrenic patients may strengthen their capability in facing the pressure in the family and managing the problems caused by their mentally ill parents, reduce their perceived stress and promote their psychological well-being.

Throughout the process of data collection and personal interviews with the respondents, it was found that some children, appearing to be optimistic and sociable, were considered to be resilient to the stressful family environment. Nevertheless, there were still a significant proportion of adolescent children facing considerable stress, experiencing psychological struggles and being vulnerable to mental health problems under the impact of their parents' mental illness. They were in need of professional assistance though they seldom voiced out their problems and actually their help seeking pattern always showed that they were less likely to turn to professionals for help.

Under the working environment with huge work load and great demands from clients, it is an uneasy task for the psychiatric social workers to effectively adopt a family-centred approach as well as maintaining the quality patient-centred service. Although more attention has been given to the family functioning and parenting of the psychotic mothers with young children, the needs of the adolescent children of schizophrnenic patients are still often neglected, so is their potential positive contribution to helping the family and their mentally ill parents in coping with the chronic mental illness. It is suggested that more substantial allocation of resources may be given to the casework service in psychiatric settings, then the front-line workers may be more available to reach out to the adult caregivers as well as the adolescent children of the schizophrenic patients who deserve more concern and assistance from the professionals.

*** END ***

APPENDIX A QUESTIONNAIRE (English Version)

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PART I

Instruction: Please use a " ✓ " to indicate the number that can most nearly apply to your situation.

	In the past half a year, whether your parent who is mentally ill comes across with the situation mentioned below? If yes: what the frequency and degree are?					What is the degree of stress that bring along from the mentioned situation?			
		4 - always 3 - occassionaly 2 - rarely 1 - never				4 - very great 3 - considerable great 2 - a little great 1 - no			
		1	2	3	4	4	3	2	1
(1)	Throwing temper without reason	❐	❐	❐	❐	❐	❐	❐	❐
(2)	Emotionally being disturbed	❐	❐	❐	❐	❐	❐	❐	❐
(3)	Isolated and withdrawn	❐	❐	❐	❐	❐	❐	❐	❐
(4)	Inappropriate expression of feelings	❐	❐	❐	❐	❐	❐	❐	❐
(5)	No facial expression	❐	❐	❐	❐	❐	❐	❐	❐
(6)	Emotionally down / depressed	❐	❐	❐	❐	❐	❐	❐	❐
(7)	Bizarre thought (Being controlled or persecuted)	❐	❐	❐	❐	❐	❐	❐	❐
(8)	Having hallucination obviously	❐	❐	❐	❐	❐	❐	❐	❐
(9)	Suspicious	❐	❐	❐	❐	❐	❐	❐	❐
(10)	Sleeping disturbance	❐	❐	❐	❐	❐	❐	❐	❐
(11)	Self-muttering	❐	❐	❐	❐	❐	❐	❐	❐
(12)	Poor personal hygiene	❐	❐	❐	❐	❐	❐	❐	❐
(13)	Having ill feeling or hatred towards another	❐	❐	❐	❐	❐	❐	❐	❐
(14)	Bizarre belief	❐	❐	❐	❐	❐	❐	❐	❐
(15)	Having suicidal thought	❐	❐	❐	❐	❐	❐	❐	❐

	1	2	3	4	4	3	2	1
(16) Having self-destructive behavior	❒	❒	❒	❒	❒	❒	❒	❒
(17) Having disturbing behavior at home	❒	❒	❒	❒	❒	❒	❒	❒
(18) Having relapse at home	❒	❒	❒	❒	❒	❒	❒	❒
(19) Refuse medication	❒	❒	❒	❒	❒	❒	❒	❒
(20) Refuse follow-up treatment	❒	❒	❒	❒	❒	❒	❒	❒
(21) Become glassy at home	❒	❒	❒	❒	❒	❒	❒	❒
(22) Waste money	❒	❒	❒	❒	❒	❒	❒	❒
(23) Over smoking	❒	❒	❒	❒	❒	❒	❒	❒
(24) Causing disturbance due to excessive drinking	❒	❒	❒	❒	❒	❒	❒	❒
(25) Lack of insight	❒	❒	❒	❒	❒	❒	❒	❒
(26) Poor concentration	❒	❒	❒	❒	❒	❒	❒	❒
(27) Lack of working motivation	❒	❒	❒	❒	❒	❒	❒	❒
(28) Passive	❒	❒	❒	❒	❒	❒	❒	❒
(29) Show no response to others	❒	❒	❒	❒	❒	❒	❒	❒
(30) Unwilling to do the housework	❒	❒	❒	❒	❒	❒	❒	❒

During these 6 months, have you encountered the following psychological experience?

(31) You are anxious as you have to make an appointment with a psychiatric rehabilitation professional, such as doctor, nurse and social worker.	❒	❒	❒	❒	❒	❒	❒	❒
(32) You are upset by having to take care of your parent who has an unstable state of mind.	❒	❒	❒	❒	❒	❒	❒	❒
(33) You feel embarrassed to attending social events with your parent who has mental problems.	❒	❒	❒	❒	❒	❒	❒	❒
(34) You are ashamed of telling people about your parent who has mental problems.	❒	❒	❒	❒	❒	❒	❒	❒

(35) You feel guilty that you have not noticed the symptoms and taken appropriate measures before the relapse of your parent's mental illness.	❒	❒	❒	❒	❒	❒	❒	❒
(36) You feel sad that you cannot communicate clearly with your parent who has mental problems.	❒	❒	❒	❒	❒	❒	❒	❒
(37) You feel annoyed that you have to treat your parent who has mental problems as if you are his/her parent.	❒	❒	❒	❒	❒	❒	❒	❒
(38) You are confused of having to face the unusual behaviours of your parent who has mental problems.	❒	❒	❒	❒	❒	❒	❒	❒

- Within these six months, has your parent who is mentally ill induced the following situations:

(39) You have to take up more housework.	❒	❒	❒	❒	❒	❒	❒	❒
(40) You have to pay visits to your parent who is in the hospital.	❒	❒	❒	❒	❒	❒	❒	❒
(41) Financial problem in the family.	❒	❒	❒	❒	❒	❒	❒	❒
(42) Your daily living is affected.	❒	❒	❒	❒	❒	❒	❒	❒
(43) Disagreement among family members.	❒	❒	❒	❒	❒	❒	❒	❒
(44) Your social life is affected.	❒	❒	❒	❒	❒	❒	❒	❒
(45) Complaints from neighbours.	❒	❒	❒	❒	❒	❒	❒	❒

PART II

Have you ever encountered the following? Please fill in the appropriate number:

1. - Impossible to do
2. - Moderately impossible to do
3. - Slightly possible to do
4. - Occasionally possible to do
5. - Slightly easy to do
6. - Moderately easy to do
7. - Extremely easy to do

1. Start a conversation with a boy or a girl whom you don't know very well ( )
2. Express your opinion to a group of kids on a subject which is of interest to you ( )
3. Join a group of kids in the school cafeteria for lunch ( )
4. Work on a project with a student you don't know very well ( )
5. Help make a new student feel comfortable with your group of friends ( )
6. Share with a group of kids an interesting experience you once had ( )
7. Put yourself in a new and different social situation ( )
8. Volunteer to help organize a school dance ( )
9. Ask a group of kids who are planning to go to a movie if you can join them ( )
10. Stand up for your rights when someone accuse you of doing something you have not done ( )
11. Get invited to a party that's being given by one of the most popular kids in the class ( )
12. Keep up your side of the conversation ( )
13. Be involved in group activities ( )
14. Find someone to spend recess with ( )
15. Wear the kind of clothes you like even if they are different from what others wear ( )

16. In a line-up, tell a student who pushes in front of you to wait for his or her turn ( )

17. Stand up for yourself when another kid in your class makes fun of you ( )

18. Help a student who is visiting your school for a short time to have fun and interesting experiences ( )

19. Join a school club and sports team ( )

20. Express your feelings to another kid ( )

21. Ask someone come to your house on a Saturday ( )

22. Ask someone to go for a school dance or movie with you ( )

23. Go to a party where you are sure you won't know any of the kids ( )

24. Ask another student for help when you need it ( )

25. Make friends with kids of your age ( )

PART III

You may or may not agree with the following questions. Please review carefully and pick the answer that suit you most:

1. - Strongly disagree
2. - Disagree
3. - Agree
4. - Strongly agree

	1	2	3	4
1. On the whole, I am satisfied with myself	❒	❒	❒	❒
2. At times I think I am no good at all	❒	❒	❒	❒
3. I feel that I have a number of good qualities	❒	❒	❒	❒
4. I am able to do things as well as most of other people	❒	❒	❒	❒
5. I feel I do not have much to be proud of	❒	❒	❒	❒
6. I certainly feel useless at times	❒	❒	❒	❒
7. I feel that I am a person of worth	❒	❒	❒	❒
8. I wish I could have more respect for myself	❒	❒	❒	❒
9. All in all, I am inclined to think that I am a failure	❒	❒	❒	❒
10. I take a positive attitude towards myself	❒	❒	❒	❒

PART IV

Instructions : The following are some multiple choice questions on schizophrenia. If the sentence is true to you, please circle the word "Yes"; if you think the sentence is wrong, please circle "No" and "Not sure" when you do not have a definite answer.

* You can only choose one answer for each question.

(1) Schizophrenia means splitting personality.	(1) [Yes]	[No]	[Not Sure]
(2) The intelligence level of a schizophrenic is poorer than an average person.	(2) [Yes]	[No]	[Not Sure]
(3) Generally speaking, a schizophrenic patient has a greater tendency of hurting himself /herself.	(3) [Yes]	[No]	[Not Sure]
(4) The short-term memory of most schizophrenic patients has been damaged.	(4) [Yes]	[No]	[Not Sure]
(5) Generally speaking, schizophrenic patients are more aggressive.	(5) [Yes]	[No]	[Not Sure]
(6) Schizophrenics easily get worried.	(6) [Yes]	[No]	[Not Sure]
(7) Most schizophrenic patients have a suicidal tendency.	(7) [Yes]	[No]	[Not Sure]
(8) Most schizophrenic patients are having autism at the same time.	(8) [Yes]	[No]	[Not Sure]
(9) Most schizophrenic patients are poor in budgeting.	(9) [Yes]	[No]	[Not Sure]
(10) Most schizophrenics are usually lazy at work.	(10) [Yes]	[No]	[Not Sure]
(11) Schizophrenic patients often deliberate absurd behaviors.	(11) [Yes]	[No]	[Not Sure]
(12) Most of the schizophrenic patients are lacking of determination.	(12) [Yes]	[No]	[Not Sure]
(13) Most of the schizophrenic patients are stubborn.	(13) [Yes]	[No]	[Not Sure]
(14) Generally speaking, schizophrenic patients are poor in impulse control.	(14) [Yes]	[No]	[Not Sure]
(15) Most schizophrenics are socially withdrawn.	(15) [Yes]	[No]	[Not Sure]

(16) It is more easily for the lower class / grassroots people to suffer from schizophrenia.	(16)	[Yes]	[No]	[Not Sure]
(17) The chance of having schizophrenia is nearly the same between two sexes.	(17	[Yes]	[No]	[Not Sure]
(18) If your parents or siblings are schizophrenics, you have a higher chance of becoming one.	(18)	[Yes]	[No]	[Not Sure]
(19) If the state of mind of a schizophrenic is more stable, he/she can voluntarily take less medicine.	(19)	[Yes]	[No]	[Not Sure]
(20) Lower socio-economic status is one of the causes for the relapse of schizophrenia.	(20)	[Yes]	[No]	[Not Sure]
(21) Experiencing stressful life events is one of the causes of schizophrenia.	(21)	[Yes]	[No]	[Not Sure]
(22) "Largactil" and "Haloperidol" are the two commonly used medicine for schizophrenia.	(22)	[Yes]	[No]	[Not Sure]
(23) Taking medicine over a long period of time is the only way to treat schizophrenia.	(23)	[Yes]	[No]	[Not Sure]
(24) Losing appetite is one of the side-effects of anti-psychotic drugs.	(24)	[Yes]	[No]	[Not Sure]
(25) Generally speaking, the possibility of relapse will be reduced with age.	(25)	[Yes]	[No]	[Not Sure]
(26) Schizophrenic patients may seek medical consultation from the concerned clinic/hospital before the date of appointment if needed.	(26)	[Yes]	[No]	[Not Sure]
(27) The regional hospitals managed by the Hong Kong Hospital Authority all provide bedspaces for psychiatric patients.	(27)	[Yes]	[No]	[Not Sure]
(28) One may call the hot-line service of the Social Welfare Department if a mental patient relapses.	(28)	[Yes]	[No]	[Not Sure]
(29) Most of the the residents living in the half-way house are male.	(29)	[Yes]	[No]	[Not Sure]
(30) The Mental Health Association of Hong Kong has already started a "telephone inquiry service for mental health".	(30)	[Yes]	[No]	[Not Sure]

(31) The service provided by day hospital has to be arranged by social workers.	(31)	[Yes]	[No]	[Not Sure]
(32) The Labour Department has set up a Selective Placement Service to seek jobs for ex-mental patients with doctor's referral.	(32)	[Yes]	[No]	[Not Sure]
(33) Ex-mental patients who have limited working capacity can attend the day training centre or sheltered workshop.	(33)	[Yes]	[No]	[Not Sure]
(34) All schizophrenic patients are elighible to apply for Disability Allowance.	(34)	[Yes]	[No]	[Not Sure]
(35) A "Resources Centre" for the family members of mental patients has not yet been commenced.	(35)	[Yes]	[No]	[Not Sure]

PART V

Instructions : The following are some questions about your feelings toward the mentally ill. Please tick the appropriate boxes.

Example : Are you willing to study together with this person? ❒ Yes ❒ No
If willing, please tick "yes", otherwise "no".

(1) Are you willing to work with an ex-mental patient ? ❒ Yes ❒ No

(2) Are you willing to work under an ex-mental patient ? ❒ Yes ❒ No

(3) If you are an employer, are you willing to hire an ex-mental patient ? ❒ Yes ❒ No

(4) Are you willing to invite an ex-mental patient as a guest to a social gathering at your home ? ❒ Yes ❒ No

(5) Are you willing to have an ex-mental patient as your neighbor ? ❒ Yes ❒ No

(6) Are you willing to live under the same household with an ex-mental patient? ❒ Yes ❒ No

(7) Are you willing to marry an ex-mental patient (assume that personality and interest are compatible) ? ❒ Yes ❒ No

PART VI

Please read this carefully.

We should like to know if you have had any medical complaints, and how your health has been in general, over the past four weeks. Please answer ALL the questions on the following pages simply by underlining the answer which you think most nearly applies to you. Remember that we want to know about present and recent complaints, not those that you had in the past.

It is important that you try to answer ALL the questions.

Thank you very much for your co-operation.

Have you recently

1. been able to concentrate on whatever you're doing ?

   ❒ Better than usual ❒ Same as usual
   ❒ Less than usual ❒ Much less than usual

2. lost much sleep over worries ?

   ❒ Not at all ❒ No more than usual
   ❒ Rather more than usual ❒ Much more than usual

3. been having restless, disturbed nights ?

   ❒ Not at all ❒ No more than usual
   ❒ Rather more than usual ❒ Much more than usual

4. been managing to keep yourself busy and occupied ?

   ❒ More than usual ❒ Same as usual
   ❒ Less than usual ❒ Much less than usual

5. been getting out of the house as much as usual ?

   ❒ More than usual ❒ Same as usual
   ❒ Less than usual ❒ Much less than usual

6. been managing as well as most people do ?

   ❒ More than usual ❒ Same as usual
   ❒ Rather less than usual ❒ Much less than usual

7. been feeling on the whole that you were doing things well ?

❒ Better than usual ❒ About the same
❒ Less well than usual ❒ Much less well

8. been satisfied with the way you carried out your task ?

❒ Better than usual ❒ About same as usual
❒ Less well than usual ❒ Much less well

9. been able to feel warmth and affection for those near to you ?

❒ Better than usual ❒ About same as usual
❒ Less well than usual ❒ Much less well

10. been finding it easy to get on with other people ?

❒ Better than usual ❒ About same as usual
❒ Less well than usual ❒ Much less well

11. spent much time chatting with people ?

❒ Not at all ❒ No more than usual
❒ Rather more than usual ❒ Much more than usual

12. felt that you are playing a useful part in things ?

❒ More than usual ❒ Same as usual
❒ Less than usual ❒ Much less than usual

13. felt capable of making decisions about things ?

❒ More than usual ❒ Same as usual
❒ Less than usual ❒ Much less than usual

14. felt constantly under strain ?

❒ Much less than usual ❒ No more than usual
❒ Rather more than usual ❒ Much more than usual

15. felt that you couldn't overcome your difficulties ?

❒ Much less than usual ❒ No more than usual
❒ Rather more than usual ❒ Much more than usual

16. been finding life a struggle all the time ?

❒ Much less than usual
❒ Rather more than usual
❒ No more than usual
❒ Much more than usual

17. been able to enjoy your normal day-to-day activities ?

❒ More than usual
❒ Less than usual
❒ Same as usual
❒ Much less than usual

18. been taking things hard ?

❒ Much less than usual
❒ Rather more than usual
❒ No more than usual
❒ Much more than usual

19. been getting scared or panicky for no good reason ?

❒ Much less than usual
❒ Rather more than usual
❒ No more than usual
❒ Much more than usual

20. been able to face up to your problems ?

❒ More than usual
❒ Less than usual
❒ Same as usual
❒ Much less than usual

21. found everything getting on top of you ?

❒ Much less than usual
❒ Rather more than usual
❒ No more than usual
❒ Much more than usual

22. been feeling unhappy and depressed ?

❒ Much less than usual
❒ Rather more than usual
❒ No more than usual
❒ Much more than usual

23. been losing confidence in yourself ?

❒ Much less than usual
❒ Rather more than usual
❒ No more than usual
❒ Much more than usual

24. been thinking of yourself as a worthless person ?

❒ Much less than usual
❒ Rather more than usual
❒ No more than usual
❒ Much more than usual

25. felt that life is entirely hopeless ?

❒ Much less than usual
❒ Rather more than usual
❒ No more than usual
❒ Much more than usual

26. been feeling hopeful about your own future ?

- ❒ More than usual
- ❒ About same as usual
- ❒ Less than usual
- ❒ Much less hopeful

27. been feeling reasonably happy in all things considered ?

- ❒ More than usual
- ❒ About same as usual
- ❒ Less than usual
- ❒ Much less hopeful

28. been feeling nervous and strung-up all the time ?

- ❒ Much less than usual
- ❒ No more than usual
- ❒ Rather more than usual
- ❒ Much more than usual

29. felt that life isn't worth living ?

- ❒ Much less than usual
- ❒ No more than usual
- ❒ Rather more than usual
- ❒ Much more than usual

30. found at times you couldn't do anything because you are too nervous ?

- ❒ Much less than usual
- ❒ No more than usual
- ❒ Rather more than usual
- ❒ Much more than usual

PART VII

Instruction: Please use a " ✓ " to indicate the number that can most nearly apply to you.

1. Strongly Disagree
2. Moderately Disagree
3. A Littler Disagree
4. A Little Agree
5. Moderately Agree
6. Strongly Agree

		1	2	3	4	5	6
1.	I look forward to the future with hope and enthusiasm.	❐	❐	❐	❐	❐	❐
2.	I might as well give up because I can't make things better for myself.	❐	❐	❐	❐	❐	❐
3.	When things are going bad, I am helped by knowing they can't stay that way forever.	❐	❐	❐	❐	❐	❐
4.	I can't imagine what my life would be like in 10 years.	❐	❐	❐	❐	❐	❐
5.	I have enough time to accomplish the things I mostly want to do.	❐	❐	❐	❐	❐	❐
6.	In the future, I expect to succeed in what concerns me most.	❐	❐	❐	❐	❐	❐
7.	My future seems dark to me.	❐	❐	❐	❐	❐	❐
8.	I expect to get more of good things in life than the average person.	❐	❐	❐	❐	❐	❐
9.	I just don't get the breaks, and there's no reason to believe I will in the future.	❐	❐	❐	❐	❐	❐
10.	My past experiences have prepared me well for my future.	❐	❐	❐	❐	❐	❐
11.	All I can see ahead of me is unpleasantness rather than pleasantness.	❐	❐	❐	❐	❐	❐
12.	I don't expect to get what I really want.	❐	❐	❐	❐	❐	❐

1. Strongly Disagree
2. Moderately Disagree
3. A Littler Disagree
4. A Little Agree
5. Moderately Agree
6. Strongly Agree

		1	2	3	4	5	6
13.	When I look ahead to the future, I expect I will be happier than I am now.	❒	❒	❒	❒	❒	❒
14.	Things just won't work out the way I want them to be.	❒	❒	❒	❒	❒	❒
15.	I have great faith in the future.	❒	❒	❒	❒	❒	❒
16.	I never get what I want so it's foolish to want anything.	❒	❒	❒	❒	❒	❒
17.	It is very unlikely that I will get any real satisfaction in the future.	❒	❒	❒	❒	❒	❒
18.	The future seems vague and uncertain to me.	❒	❒	❒	❒	❒	❒
19.	I can look forward to more good times than bad times.	❒	❒	❒	❒	❒	❒
20.	There's no use in really trying get something I want because I probably won't get it.	❒	❒	❒	❒	❒	❒

PART VIII

Instructions : The following are some questions on your particulars and that of your family. Please tick the appropriate boxes or where appropriate, write the answer above the line.

1. Sex : Male ❒ Female ❒

2. Age : 12 ❒ 13 ❒ 14 ❒ 15 ❒
16 ❒ 17 ❒ 18 ❒ 19 ❒

3a. Your relationship with the psychiatric patient is :

Father ❒ Mother ❒ Adopted father ❒ Adopted mother ❒ Others ❒

3b. His/her age is: 35 or below ❒ 36 - 45 ❒ 46 - 55 ❒ 56 & above ❒

4. The clinic or hospital that your parent is undergoing treatment for mental problems:

_____

5. How many years has he/she undergone treatment :

2 years or below ❒ 3 - 5 years ❒ 6 - 8 years ❒
9 - 12 years ❒ 13 - 15 years ❒ 16 years or above ❒

6. Is he/she currently living in a hospital? Yes ❒ No ❒

7. Your type of accommodation is:

Self-owned flat ❒ Public Housing ❒
Home Ownership Scheme ❒ Rented Flat ❒
Rented Room ❒ Others ❒

8. Your education level is :

Secondary School or below ❒ Form 1 ❒ Form 2 ❒
Form 3 ❒ Form 4 ❒ Form 5 ❒

9. How many family members are you now living with?

1 ❒ 2 ❒ 3 ❒ 4 ❒ 5 ❒ 6 ❒
7 ❒ 8 ❒ 9 or above ❒

10. Are you parents alive ? Father is alive ❒ Mother is alive ❒

11a. Do you have other schizophrenic(s) in your family ? Yes ❒ No ❒

11b. If yes, who is he/she? Brother ❒ Sister ❒ The other parent ❒

Grandfather ❒ Grandmother ❒

12a. How many brothers/sisters do you have?: Elder Brother _____
Younger Brother _____
Elder Sister _____
Younger Sister _____

b. Your rank is : 1❒ 2❒ 3❒ 4❒ 5❒

13. Your relationship with your mentally ill parent is :

Very Bad ❒ Bad ❒ Fair ❒ Good ❒ Very Good ❒
Not Applicable ❒

14. Are you currently living with the parent who has mental problems? Yes ❒ No ❒

15. Your parents' education levels are :

Father	No schooling	❒	Mother	No Schooling ❒
	Primary	❒		Primary ❒
	Secondary	❒		Secondary ❒
	University	❒		University ❒

16. The occupation of your parents is :

Father	Manual Worker	❒	Mother	Manual Worker ❒
	Office Worker	❒		Office Worker ❒
	Unemployed	❒		Housewife ❒

17. The total family income per month is around :

$5,000 or below ❒ $5,001 to $10,000 ❒
$10,001 to $15,000 ❒ $15,001 to $20,000 ❒ $20,001 & above ❒

18. The major source of your family income is :

Father's income ❒ Mother's income ❒ Siblings' income ❒
Parents' and siblings' income ❒ Rental ❒ Various allowances ❒
Others ❒

19. What do you think about the relationship between your parents :

Very bad ❒ Bad ❒ Fair ❒ Good ❒ Very Good ❒

20. The marital status of your parents is :

Not registered ❒ Registered ❒ Separated ❒
Divorced ❒ Others, Please specify _____

21. Who is the major family member who looks after your parent who has schizophrenia?

Father/Mother ❒ Siblings ❒ Relatives ❒
Grandparents ❒ Yourself ❒

22. In the last six months, have you accompanied your parent who has schizophrenia to see a doctor(s) and/or a social worker(s)? Yes ❒ No ❒

23. How effective do you think is the doctor's assistance to the patient?

Completely not effective ❒ Not Effective ❒ Effective ❒
Very Effective ❒

24. How effective do you think is the social worker's assistance to the patient?

Completely not effective ❒ Not Effective ❒
Effective ❒ Very Effective ❒

25. Do you have any religious belief? Yes ❒ No ❒

26. If you have religious belief, you are a

Catholic ❒ Protestant ❒ Buddhist ❒ Others ❒

27. What are the most needed assistance required by your schizophrenic parent? (Please prioritize your answers)

a. Financial assistance ❒
b. Psychological assistance / counselling ❒
c. Interpersonal skills training ❒
d. Assistance in housework ❒
e. Mental health education ❒
f. Others, please specify _____

28. What assistance do you need most? (Please prioritize your answers)

a. Education on management of psychiatric problems ❒
b. Counselling service ❒
c. Interpersonal skills training ❒
d. Training on stress management ❒
e. Others, please specify _____

APPENDIX B QUESTIONNAIRE (Chinese Version)

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第一部份

指示： 請填上你認為最能夠代表你情況的數字

◆ 在過去半年裏，你患有精神病的父母是否有下列的情況？ 如有：它們的出現頻密程度是怎樣呢?

各個問題的出現可能帶給你的壓力有多大呢？

		4 經常有	3 間中有	2 極少有	1 從來沒有	4 非常大	3 相當大	2 少許	1 完全沒有
(1)	無故發脾氣	□	□	□	□	□	□	□	□
(2)	情緒困擾	□	□	□	□	□	□	□	□
(3)	孤獨退縮	□	□	□	□	□	□	□	□
(4)	表現不恰當的情感	□	□	□	□	□	□	□	□
(5)	面無表情	□	□	□	□	□	□	□	□
(6)	情緒低落	□	□	□	□	□	□	□	□
(7)	思想怪異（如被控制或迫害）	□	□	□	□	□	□	□	□
(8)	有明顯幻覺	□	□	□	□	□	□	□	□
(9)	多疑	□	□	□	□	□	□	□	□
(10)	有睡眠障碍	□	□	□	□	□	□	□	□
(11)	自言自語	□	□	□	□	□	□	□	□

	4 經常有	3 間中有	2 極少有	1 從來沒有	4 非常大	3 相當大	2 少許	1 完全沒有
(12) 不顧個人衞生	□	□	□	□	□	□	□	□
(13) 對人有敵意	□	□	□	□	□	□	□	□
(14) 信念怪誕	□	□	□	□	□	□	□	□
(15) 有自殺意念	□	□	□	□	□	□	□	□
(16) 有自毀行為	□	□	□	□	□	□	□	□
(17) 在家中擾攘	□	□	□	□	□	□	□	□
(18) 在家中精神病復發	□	□	□	□	□	□	□	□
(19) 拒絕服藥	□	□	□	□	□	□	□	□
(20) 拒絕覆診	□	□	□	□	□	□	□	□
(21) 呆在家中	□	□	□	□	□	□	□	□
(22) 胡亂花錢	□	□	□	□	□	□	□	□
(23) 抽煙過度	□	□	□	□	□	□	□	□
(24) 醉酒鬧事	□	□	□	□	□	□	□	□
(25) 缺乏洞察力	□	□	□	□	□	□	□	□

	4 經常有	3 間中有	2 極少有	1 從來沒有	4 非常大	3 相當大	2 少許	1 完全沒有
(26) 缺乏專注力	□	□	□	□	□	□	□	□
(27) 缺乏工作動机	□	□	□	□	□	□	□	□
(28) 被動	□	□	□	□	□	□	□	□
(29) 對人缺乏回應	□	□	□	□	□	□	□	□
(30) 不肯做家務	□	□	□	□	□	□	□	□
◆ 在這半年裏，你是否過以下的心理狀況？								
(31) 你要約見精神科的康復專業人員：如醫生、護士、社工而感到焦慮	□	□	□	□	□	□	□	□
(32) 你要在家照顧精神不穩定的父／母而感到不滿	□	□	□	□	□	□	□	□
(33) 與患精神病的父/母出席一些社交場合，而感到尷尬	□	□	□	□	□	□	□	□
(34) 向別人提及家有精神病的父／母而感到羞愧	□	□	□	□	□	□	□	□
(35) 在患有精神病的父／母病發前，你因未能及時察覺異樣而作出防範，所以感到罪疚	□	□	□	□	□	□	□	□

	4 經常有	3 間中有	2 極少有	1 從來沒有	4 非常大	3 相當大	2 少許	1 完全沒有
(36) 不能清楚地與患有精神病的父／母溝通而感到無奈	□	□	□	□	□	□	□	□
(37) 要像父母般照顧患有精神病的父／母，而感到惱怒	□	□	□	□	□	□	□	□
(38) 要面對患有精神病的父/母的異常行為，而感到混亂	□	□	□	□	□	□	□	□

◆ 在這半年裏，你患有精神病的父／母是否引致以下的事情發生？

(39) 你要負擔很多家務	□	□	□	□	□	□	□	□
(40) 你要探望留院的父／母	□	□	□	□	□	□	□	□
(41) 家庭經濟出現問題	□	□	□	□	□	□	□	□
(42) 日常家居生活受到影响	□	□	□	□	□	□	□	□
(43) 家庭成員之間的不和	□	□	□	□	□	□	□	□
(44) 你的社交生活受到影响	□	□	□	□	□	□	□	□
(45) 遭受鄰居投訴	□	□	□	□	□	□	□	□

第二部份

指示：　在你以往的經歷中，是否能夠做到以下題目所提及的情況？
請填上最適合你現況的數字。

7	6	5	4	3	2	1
十分容易做到	頗為容易做到	也算容易做到	有時可能做到	少許可能做到	頗為不可能做到	完全不可能做到

(1)	主動與一個不太熟悉的人談話	(1)	〔_____〕
(2)	當一班朋友正在討論一個我喜歡的題目時，參予表達自己的意見	(2)	〔_____〕
(3)	與一些同學一起吃午飯	(3)	〔_____〕
(4)	與一個不太熟識的同學合作做一份工作	(4)	〔_____〕
(5)	幫助一個新認識的同學融入我自己的朋友圈子	(5)	〔_____〕
(6)	向一班朋友分享一些我曾遇過的有趣經驗	(6)	〔_____〕
(7)	讓自己去參予一個以前未參予過的社交場合	(7)	〔_____〕
(8)	自願參予組織校內的活動	(8)	〔_____〕
(9)	當一些朋友一起外出娛樂時，主動要求加入他們的活動	(9)	〔_____〕

7	6	5	4	3	2	1
十分容易	頗爲容易	也算容易	有時可能	少許可能	頗爲不可能	完全不可能

(10) 當有人指責我做了一件從沒有做過的事情時，我為自己辯護 (10) 〔_____〕

(11) 被朋友邀請到他／她家中參予一些活動 (11) 〔_____〕

(12) 在與人談話中，講出我想講的話 (12) 〔_____〕

(13) 投入群体的生活 (13) 〔_____〕

(14) 在休閒時間，找朋友一起活動 (14) 〔_____〕

(15) 穿著自己喜歡的衣服，儘管這些服式與別不同 (15) 〔_____〕

(16) 見到另一個學生在排隊時在前面推撞，我出聲要求他／她守秩序 (16) 〔_____〕

(17) 當在班中有人取笑我時，我為自己站起來說話 (17) 〔_____〕

(18) 在學校開放日時，我幫助來參觀的其它學校學生渡過一段有趣的時光 (18) 〔_____〕

(19) 參加學校的團体組織或体育隊伍 (19) 〔_____〕

(20) 把我的感受告訴另一個朋友 (20) 〔_____〕

(21) 邀請朋友在週末時來我家 (21) 〔_____〕

		7 十分容易	6 頗爲容易	5 也算容易	4 有時可能	3 少許可能	2 頗爲不可能	1 完全不可能
(22)	邀請朋友與我一起參加派對或看電影			(22)		〔_____〕		
(23)	參加一個我什麼人都不認識的聚會或派對			(23)		〔_____〕		
(24)	當我有需要時，我向另一個同學求助			(24)		〔_____〕		
(25)	與年齡相若的人交朋友			(25)		〔_____〕		

第三部份

指示： 以下共有10句你可能同意或不同意的句子。 請小心閱讀每一句子，並按著你對於某一句子的感覺在該句子後面圈上你認為最能夠代表你的感受的答案。

如果你十分不同意該句子 ==> 請圈 ①
如果你不同意該句子 ==> 請圈 ②
如果你同意該句子 ==> 請圈 ③
如果你十分同意該句子 ==> 請圈 ④

請不要花太多時間在任何一句句子上。 請回答所有問題。

		十分不同意	不同意	同意	十分同意
1.	總括來說，我對自己感到滿意。	1	2	3	4
2.	有些時候，我會覺得自己是一無是處。	1	2	3	4
3.	我感到自己是有一些優點。	1	2	3	4
4.	我能夠把事情做得和很多其他人所做到的一樣好。	1	2	3	4
5.	我覺得自己沒有什麼可以值得引以自豪的。	1	2	3	4
6.	有些時候，我確實地感到自己是一無是處。	1	2	3	4
7.	我感到自己是一個有價值的人，而我的價值起碼並不比別人低。	1	2	3	4
8.	我希望能夠有更多對自己的尊重。	1	2	3	4
9.	總括來說，我傾向於感到自己是失敗的。	1	2	3	4
10.	我抱著積極的態度面對自己。	1	2	3	4

第四部份

指示：　以下是問及一些有關精神分裂症的『是非』題。如你認為句子的內容是正確的，請圈上『是』；但若你認為句子內容不正確的，請圈上『非』；如你不肯定問題的答案，請圈上『不肯定』。

※　每條問題只可選擇一個答案

(1)	精神分裂症即是性格分裂	(1)　〔是〕〔非〕〔不肯定〕
(2)	精神分裂症的病人的智力較一般人差	(2)　〔是〕〔非〕〔不肯定〕
(3)	一般而言，精神分裂症的病人對自己作出傷害的可能性比其他人高	(3)　〔是〕〔非〕〔不肯定〕
(4)	大部份的精神分裂症病人的記憶能力受到損害	(4)　〔是〕〔非〕〔不肯定〕
(5)	一般而言，精神分裂症的病人都是衝動的	(5)　〔是〕〔非〕〔不肯定〕
(6)	精神分裂症的病人都是容易憂心的	(6)　〔是〕〔非〕〔不肯定〕
(7)	大多數精神分裂症的病人都有自殺傾向	(7)　〔是〕〔非〕〔不肯定〕
(8)	大多數精神分裂症的病人都同時患有自閉症	(8)　〔是〕〔非〕〔不肯定〕
(9)	有大多數精神分裂症的病人都是不善理財的	(9)　〔是〕〔非〕〔不肯定〕

(10) 大多數精神分裂症的病人都是傾於懶惰的 (10) 〔是〕〔非〕〔不肯定〕

(11) 一般的精神分裂症病人會隨時有怪誕行為 (11) 〔是〕〔非〕〔不肯定〕

(12) 大多數精神分裂症的病人都是缺乏意志力 (12) 〔是〕〔非〕〔不肯定〕

(13) 大多數精神分裂症的病人都是固執的 (13) 〔是〕〔非〕〔不肯定〕

(14) 一般而言，精神分裂症的病人控制自己衝動的能力都是差的 (14) 〔是〕〔非〕〔不肯定〕

(15) 大部份精神分裂症的病人都是孤獨退縮的 (15) 〔是〕〔非〕〔不肯定〕

(16) 在社會階級底層的人仕容易患上精神分裂症 (16) 〔是〕〔非〕〔不肯定〕

(17) 男性和女性患上精神分裂症的机會是差不多均等的 (17) 〔是〕〔非〕〔不肯定〕

(18) 當你的父母或兄弟姊妹患上精神分裂症，你也有較高机會患上此病 (18) 〔是〕〔非〕〔不肯定〕

(19) 若果精神分裂症的病人精神狀態已經穩定，他是可以自行減藥 (19) 〔是〕〔非〕〔不肯定〕

(20) 較低的社會經濟地位是引致精神分裂症復發的因素之一 (20) 〔是〕〔非〕〔不肯定〕

(21)	有壓力的人生事故，是引致精神分裂症的原因之一	(21) 〔是〕〔非〕〔不肯定〕
(22)	"Lagactil" 及 "Haloperidol" 是治療精神分裂症的常用藥物	(22) 〔是〕〔非〕〔不肯定〕
(23)	長期服藥是治療精神分裂症的唯一方法	(23) 〔是〕〔非〕〔不肯定〕
(24)	失去食慾，是服用治療精神分症的藥物而引起的普遍副作用之一	(24) 〔是〕〔非〕〔不肯定〕
(25)	一般而言，精神分裂症的病人年紀愈大，愈少机會病發	(25) 〔是〕〔非〕〔不肯定〕
(26)	精神病患者在覆診日期以前可以隨時返回所屬的診所／醫院求診	(26) 〔是〕〔非〕〔不肯定〕
(27)	醫管局屬下的區域性醫院，都設有精神科病床	(27) 〔是〕〔非〕〔不肯定〕
(28)	如遇有精神病人病發時，可致電社會福利署的熱線服務求助	(28) 〔是〕〔非〕〔不肯定〕
(29)	目前在中途寂宿的社友，都是以男性居多	(29) 〔是〕〔非〕〔不肯定〕
(30)	香港心理衞生會的『心理健康資訊電話服務』(27720047)已經開始	(30) 〔是〕〔非〕〔不肯定〕
(31)	日間醫院的服務是由社工安排的	(31) 〔是〕〔非〕〔不肯定〕

(32) 勞工處設有展能就業科，可以幫助患有精神分裂症的康復者就業，但要由醫生轉介

(32) 〔是〕〔非〕〔不肯定〕

(33) 工作能力較差的精神病復者，可以參加展能中心或庇護工場

(33) 〔是〕〔非〕〔不肯定〕

(34) 精神分裂症的患者都可以嘗試申請傷殘津貼

(34) 〔是〕〔非〕〔不肯定〕

(35) 為精神病患者的家屬而設的『家屬資源中心』，還未開始服務

(35) 〔是〕〔非〕〔不肯定〕

第五部份

指示：　以下是知道你對於一位曾患精神病的人的感受。
請圈上你認為是正確的答案。

例子：　你是否願意與這一個人起溫習課？　〔是〕　〔否〕

如果你願意與這一個人一起溫習功課，請圈上『是』；
如你不願意，請圈上『否』。

(1)	你是否願意與這個精神病人一齊工作？	〔是〕	〔否〕
(2)	你是否願意與這個精神病人做你的上司？	〔是〕	〔否〕
(3)	如果你是僱主，你是否願意僱用這個精神病人？	〔是〕	〔否〕
(4)	如你家中請客，你是否願意邀請這個精神病人？	〔是〕	〔否〕
(5)	你是否願意與這個精神病人做鄰居？	〔是〕	〔否〕
(6)	你是否願意與這個精神病人同住一間屋？	〔是〕	〔否〕
(7)	你是否願意與這個精神病人結婚（假設性格與興趣都相同）？	〔是〕	〔否〕

第六部份

指示：　我們希望知道這數個星期裏，你有沒有感到不適，與及你的健康情況。請在合適的方格內打上☑號。

你最近：

1. 係唔係做任何事都能夠集中精神？
   a）☐ 好過平時　b）☐ 同平時一樣
   c）☐ 差過平時　d）☐ 差過平時好多

2. 係唔係擔心到不能睡覺？
   a）☐ 完全有　b）☐ 有比平時多
   c）☐ 多過平時　d）☐ 多過平時好多

3. 係唔係囉囉攣到睡得唔好？
   a）☐ 完全有　b）☐ 有比平時多
   c）☐ 多過平時　d）☐ 多過平時好多

4. 係唔係忙碌同埋充份利用時間？
   a）☐ 多過平時　b）☐ 同平時一樣用
   c）☐ 有平時咁多　d）☐ 少過平時好多

5. 係唔係好似平時出咁多街？
   a）☐ 多過平時　b）☐ 同平時一樣
   c）☐ 少過平時　d）☐ 少過平時好多

6. 處理日常事務係唔係同人地一樣咁好？
   a）☐ 好過好多人　b）☐ 大概同人地一樣
   c）☐ 有人地咁好　d）☐ 差過好多人

7. 係唔係覺得大致做事都做得幾好？
   a）☐ 好過平時　b）☐ 同平時差唔多
   c）☐ 有平時咁好　d）☐ 差過平時好多

8. 係唔係滿意自己做事的方式？
   a）☐ 滿意過平時　b）☐ 同平時差唔多
   c）☐ 有平時咁滿意　d）☐ 非常唔滿意

9. 能唔能夠親切咁對待你周圍的人？
   a）☐ 好過平時　b）☐ 同平時差唔多
   c）☐ 有平時咁好　d）☐ 差過平時好多

10. 係唔係容易同人相處？
    a）☐ 好過平時　b）☐ 同平時差唔多
    c）☐ 有平時咁多　d）☐ 差過平時好多

11. 係唔係好多時間同人傾偈？
    a）☐ 多過平時　b）☐ 同平時差唔多
    c）☐ 有平時咁多　d）☐ 少過平時好多

12. 係唔係覺得自己處處都能起作用？
    a）☐ 好過平時　b）☐ 同平時一樣
    c）☐ 有平時咁好　d）☐ 差過平時好多

13. 係唔係覺得對事情可以自己立定主意?
a) ☐ 好過平時 b) ☐ 同平時一樣
c) ☐ 冇平時咁好 d) ☐ 差過平時好多

14. 係唔係覺得成日有精神壓力?
a) ☐ 完全冇 b) ☐ 同平時差唔多
c) ☐ 多過平時 d) ☐ 多過平時好多

15. 係唔係覺得唔能夠克服自己的困難?
a) ☐ 完全冇問題 b) ☐ 同平時差唔多
c) ☐ 難過平時 d) ☐ 難過平時好多

16. 成日覺得人生好似戰場一樣?
a) ☐ 完全唔係 b) ☐ 冇比平時多
c) ☐ 多過平時少少 d) ☐ 多過平時好多

17. 能夠開心咁過你平日正常的生活?
a) ☐ 多過平時 b) ☐ 同平時一樣
c) ☐ 少過平時 d) ☐ 少過平時好多

18. 覺得自己做事非常認眞?
a) ☐ 完全唔係 b) ☐ 同平時差唔多
c) ☐ 難過平時少少 d) ☐ 難過平時好多

19. 無端端覺得好怕或者好驚?
a) ☐ 完全冇 b) ☐ 同平時差唔多
c) ☐ 多過平時少少 d) ☐ 多過平時好多

20. 能夠面對自己的困難?
a) ☐ 好過平時 b) ☐ 同平時一樣
c) ☐ 冇平時咁好 d) ☐ 非常唔能夠

21. 事情太多應付不來?
a) ☐ 完全唔係 b) ☐ 同平時差唔多
c) ☐ 多過平時少 d) ☐ 多過平時好多

22. 覺得好唔開心又悶悶不樂?
a) ☐ 完全唔係 b) ☐ 同平時差唔多
c) ☐ 多過平時少少 d) ☐ 多過平時好多

23. 對自己失了信心?
a) ☐ 完全唔係 b) ☐ 同平時差唔多
c) ☐ 多過平時少少 d) ☐ 多過平時好多

24. 覺得自己係個無用的人?
a) ☐ 完全唔係 b) ☐ 同平時差唔多
c) ☐ 多過平時少少 d) ☐ 多過平時好多

25. 覺得自己完全冇哂希望?
a) ☐ 完全唔係 b) ☐ 同平時差唔多
c) ☐ 多過平時少少 d) ☐ 多過平時好多

26. 覺得自己的將來好有希望?
a) ☐ 多過平時 b) ☐ 同平時差唔多
c) ☐ 少過平時 d) ☐ 非常有希望

27. 大致上來講，樣樣事都幾開心？

a）□ 多過平時　b）□ 同平時差唔多
c）□ 少過平時　d）□ 少過平時好多

28. 成日覺得心神不安同埋緊張？

a）□ 完全唔係　b）□ 同平時差唔多
c）□ 多過平時少少　d）□ 多過平時好多

29. 覺得唔值得繼續做人？

a）□ 完全唔係　b）□ 同平時差唔多
c）□ 多過平時少少　d）□ 多過平時好多

30. 因為神經太過緊張，覺得自己有時做任何事都做唔到？

a）□ 完全唔係　b）□ 同平時差唔多
c）□ 多過平時少少　d）□ 多過平時好多

第七部份

指示：　以下共有２０句你可能同意或不同意的句子。 請小心閱讀每一句子，並按著你對於某一句子的感覺在該句子後面圈上你認為最能夠代表你的感受的答案。

如果你十分不同意該句子　==>　請圈 ①
如果你頗為不同意該句子　==>　請圈 ②
如果你少許不同意該句子　==>　請圈 ③
如果你少許同意該句子　==>　請圈 ④
如果你頗為同意該句子　==>　請圈 ⑤
如果你十分同意該句子　==>　請圈 ⑥

		十分不同意	頗為不同意	少許不同意	少許同意	頗為同意	十分同意
(1)	我以希望和熱誠展望將來	1	2	3	4	5	6
(2)	我還是放棄好了，因為我不能令事情變得對自己更好	1	2	3	4	5	6
(3)	惡劣的情況不會永久維持，這個想法有助我去面對事情的轉壞	1	2	3	4	5	6
(4)	我無法想像：我在未來十年內的生活會是怎樣	1	2	3	4	5	6
(5)	我有充份時間去完成：我最渴望要做的事情	1	2	3	4	5	6
(6)	我期望在將來：能在我最關注事上得成功	1	2	3	4	5	6
(7)	對我來說，我的將來似乎是黑漆一片	1	2	3	4	5	6

		十分不同意	頗為不同意	少許不同意	少許同意	頗為同意	十分同意
(8)	我期望自己：能比一般人得到更多生活中美好的東西	1	2	3	4	5	6
(9)	我眞的一點運氣也沒有，而亦沒有任何理由去相信將來會有運氣	1	2	3	4	5	6
(10)	我以往的經歷，很足夠地預備我去面對我的將來	1	2	3	4	5	6
(11)	我可以看見我的未來:全是不愉快的	1	2	3	4	5	6
(12)	我不期望能夠得到我想要的東西	1	2	3	4	5	6
(13)	當我展望將來時，我期望我會比現在更快樂	1	2	3	4	5	6
(14)	事情總不能如我所願的發生	1	2	3	4	5	6
(15)	我對將來存有極大的信心	1	2	3	4	5	6
(16)	我從來不能得到我希望得到的，所以希望得到任何東西均是愚蠢的	1	2	3	4	5	6
(17)	我會在將來得到任何眞正的滿足感，這是十分不可能的	1	2	3	4	5	6
(18)	對我來說，將來似乎是模糊和變化無常的	1	2	3	4	5	6
(19)	我可預期，我的將來是順景多於逆景的	1	2	3	4	5	6
(20)	嘗試得到一些想得到的東西是沒有用的，因為我極大可能是得不到的	1	2	3	4	5	6

第八部份

指示： 以下是問及一些有關你個人及家庭現況的資料。 請在適當答案的旁邊: 畫上「剔」號（ ✓ ），或在線上填上正確的答案。

1. 性別: □ 男 □ 女

2. 年齡： □ 12 - 14 歲 □ 15 - 16 歲 □ 18 - 19 歲

3. a. 你與精神病患者的關係是： □ 父 □ 母 □ 養父 □ 養母 □ 其它

   b. 他們的年是： □ 40 歲或以下 □ 40 - 55 歲 □ 56 歲或以上

4. 患精神病的父/母接受治療的診所或醫院是: _____

5. 他／她接受精神科治療有多久： □ 2 年 或 以下
   □ 3 － 5 年
   □ 6 － 8 年
   □ 9 －12 年
   □ 13－15 年
   □ 16 年 或 以上

6. 現在他／她是否住院病人？ □ 是 □ 否

7. 你的居住狀況是： □ 自置私人樓宇 □ 公共房屋 □ 居屋
   □ 租一單位 □ 租一房間 □ 其它

8. 你的教育程度是： □ 中學以下 □ 中一 □ 中二
   □ 中三 □ 中四 □ 中五

9. 你家中共有多少人一起居住？ □ 1人 □ 2人 □ 3人 □ 4人
   □ 5人 □ 6人 □ 7人 □ 8人
   □ 9人 或以上

10. 你的父母是否健在？ □ 父健在 □ 母健在 □ 父母皆健在

11. a. 你家中有其他的精神病患者嗎? □ 有 □ 沒有

b. 若有,是誰? □兄弟 □姊妹 □另一位父/母 □祖父 □祖母

12. a. 你有多少兄弟姊妹? □ 兄：_____ 位 □ 弟：_____ 位
□ 姊：_____ 位 □ 妹：_____ 位

b. 你在兄弟姊妹中的排行是： □ 1 □ 2 □ 3 □ 4 □ 5 或以上

13. 你與患有精神病的父母的關係是？

□ 十分差 □ 差 □ 一般 □ 好 □ 十分好 □ 不適用

14. 你現在是否與患精神病的父/母一起居住? □ 是 □ 否

15. 你父母的教育程度是: 父： □（未曾入學） 母：□（未曾入學）
□（小學） □（小學）
□（中學） □（中學）
□（大學） □（大學）

16. 你父母的職業是: 父： □（勞工） 母：□（勞工）
□（文職） □（文職）
□（失業） □（家庭主婦）

17. 你全家平均一個月的總收入大約有: □ $ 5,000 或 以下
□ $ 5,001 至 $10,000
□ $10,001 至 $15,000
□ $15,001 至 $20,000
□ $20,001 或 以上

18. 你全家的主要收來源是：

- ☐ 父親的收入
- ☐ 母親的收入
- ☐ 兄弟姊妹的收入
- ☐ 父母及兄弟姊妹的收入
- ☐ 租金收入
- ☐ 綜合援助金
- ☐ 其它

19. 你認為父親和母親的關係是：

☐ 十分差　☐差　☐ 一般　☐ 好　☐ 十分好

20. 你父母的婚姻狀況是：

- ☐ 未有註冊
- ☐ 已經註冊
- ☐ 已經分居
- ☐ 已經離婚
- ☐ 其它，請說明 _____

21. 你家中誰是患有精神病父/母的主要照顧者?

☐ 父/母　☐ 兄弟姊妹　☐ 親戚　☐ 祖父母　☐ 自己

22. 在過去六個月裏，你有沒有陪伴患精神病的父/母見過醫生或社會工作者：　☐ 有　☐ 沒有

23. 你認為醫生對精神病患者的幫助是：

☐ 完全沒有效　☐ 沒有效　☐ 一般　☐ 有效　☐ 十分有效

24. 你認為社工對精神病患者的幫助是：

☐ 完全沒有效　☐ 沒有效　☐ 一般　☐ 有效　☐ 十分有效

25. 你有沒有宗教信仰：　☐ 有　☐ 沒有

26. 若有宗教信仰，仍是：

□ 天主教
□ 基督教
□ 佛　教
□ 其　他

27. 你認為患有精神病的父/母最需要的服務是：

（請在你認為最需要的項目旁，填上 ① 次要的：② .. 如此類推）

a. □ 經濟
b. □ 心理輔導
c. □ 社交技巧訓練
d. □ 家務輔助
e. □ 精神健康教育
f. □ 其它，請說明：_____

28. 你本人最需要得到的服務是：

（請在你認為最需要的項目旁，填上　次要的：　.. 如此類推）

a. □ 認識精神病及處理有關病人的教育
b. □ 心理輔導
c. □ 社交技巧訓練
d. □ 處理壓力的技巧訓練
f. □ 其它，請說明：_____

APPENDIX C

Table 31

Mean Difference between Protestant and Non-Protestant on Social Self-Efficacy Scale (SEFF)

	Category	Mean	S.D.	t-value
Sex	Male	3.2730	0.693	-.16 N.S.
	Female	3.3009	0.925	
Age	12 - 15	3.3579	0.823	1.04 N.S.
	16 - 19	3.1665	0.818	
Religion	Non-Protestant	3.1520	0.796	-2.08*
	Protestant	3.4726	0.830	

* $P < 0.05$

N.S. : Non-Significant

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